

ADULT MEDICAL HISTORY FORM

COLLINS ORTHODONTICS

800 Lakeway Dr. - Georgetown, TX 78628 (512) 863-6113

1. ABOUT YOU

Today's Date: _____

Name: _____
Last First M. Ini.

I prefer to be called: _____ Male Female

Birthdate: ____/____/____ Age: _____

SS#: _____

Home Address: _____

City State Zip

Single Married Widowed Divorced Separated

Cell#: _____ Pager/Other#: _____

Wk#: _____ Ext: _____

DL#: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us? _____

General Dentist: _____

Last Visit Date: _____

Any Treatment Rendered? _____

2. SPOUSE INFORMATION

His/Her Name: _____

Employer: _____

Cell#: () _____ Wk#: _____

SS#: _____

Birthdate: ____/____/____ Age: _____

Person Responsible for Account: _____

Cell#: () _____ Wk#: () _____

Billing Address: _____

Relation: _____ SS#: _____

Employer: _____

3. ORTHODONTIC INSURANCE

Orthodontic Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone#: () _____

Group# (Plan, local, or Policy #): _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthdate: ____/____/____

Insured's SS#: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name: _____ Relation: _____

Wk#: _____ Hm#: _____

4. MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: () _____

Your Current physical health is:

Good Fair Poor

Are you currently under the care of a physician?

Yes No

Please explain: _____

Are you taking any prescription/over the counter drugs?

Yes No

Please list each one: _____

For women:

Are you taking birth control pills? Yes No

Are you pregnant? Yes No Week #: _____

Are you nursing? Yes No

4. MEDICAL HISTORY *continued*

Have you ever had any of the following diseases or medical problems?

- | | |
|--------------------------------------|----------------------------------|
| Y N Anemia/Radiation Treatment | Y N Heart Surgery/Pacemaker |
| Y N Artificial Bones/Joints | Y N Hemophilia/Abnormal Bleeding |
| Y N Artificial Valves | Y N Hepatitis |
| Y N Asthma Arthritis | Y N High/Low Blood Pressure |
| Y N Blood Transfusion | Y N HIV +/-AIDS |
| Y N Cancer/Chemotherapy | Y N Hospitalized for Any Reason |
| Y N Congenital Heart Defect | Y N Kidney Problems |
| Y N Diabetes/Tuberculosis | Y N Mitral Valve Prolapse |
| Y N Difficulty Breathing | Y N Psychiatric Problems |
| Y N Drug/Alcohol Abuse | Y N Rheumatic/Scarlet Fever |
| Y N Emphysema/Glaucoma | Y N Severe/Frequent Headaches |
| Y N Epilepsy/Seizure/Fainting Spells | Y N Shingles |
| Y N Fever Blisters/Herpes | Y N Sinus Problems |
| Y N Heart Attach/Stroke | Y N Ulcers/Colitis |
| Y N Heart Murmur | Y N Veneral Disease |

Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following?

- | | | |
|-------------|------------------------|----------------|
| Y N Aspirin | Y N Dental Anesthetics | Y N Penicillin |
| Y N Codeine | Y N Any Metal/Plastic | Y N Latex |

Thank you for filling out this form completely

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services

Signature

Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDA and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally retrieved the medical / dental information above with the patient named herein.

Doctor's Comments

Initials: _____ Date: _____

5. DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish?

Have you ever been evaluated for orthodontic treatment?

Yes No

Have you ever had a serious/difficult problem associated with any previous dental work?

Yes No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ / TMD)? Yes No

Your current dental health is:

Good Fair Poor

Do you like your smile? Yes No

Do your gums bleed? Yes No

Have you ever had an injury to your: Mouth Teeth Chin

Do you have any speech problems?

Do you generally breathe through your mouth?

Y N Awake?

Y N Asleep?

Do you have any missing or extra permanent teeth?

Yes No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.
