DUBUQUE ORTHODONTIC ASSOCIATES, P.C.
ADULT HEALTH HISTORY FORM

Welcome to our Office!

The following information is requested to enable us to give you the best consideration of your orthodontic problem during your initial examination in our office. In order for the orthodontist to thoroughtly diagnose any condition, he must have accurate background and health information on which to base his decisions. This information is important for our records and your health. I understand that providing incorrect information can be dangerous to my health. Please circle the appropriate response where indicated.

Thank you.

Patient's Last Name: ___________________________ First Name: ________________________ Middle Initial: ___________

Birth Date: _____________ Age: ______ Sex: Male or Female I prefer To Be Called: ______________________________

Home Phone No.:_______________________________ Cell Phone No.:____

Patient's Address: ____

City: ___________________________ State/Province: ___________________ Zip/Postal Code: ______________________

Occupation:_____________________________________ Employer:____

Business Phone No: ______________________________

Name of Spouse/Closest Relative:_____________________________ Phone No. (if different than yours):___________________

Relationship to you:_______________________________

Address (if different than yours):____

City:___________________________________ State/Province:________________ Zip/Postal Code:______________________

First & Last Names of other family members treated here:____

____

Name of your dentist:___________________________________ Date of last checkup:_____________________________

Were your teeth cleaned? Yes No

Who suggested that you might need orthodontic treatment?____

<u>Who is Financially Responsible For This Account? If self, you may skip this section.</u>

Last Name: __________________________ First Name: ___________________________Middle Initial: _________________

Address *(if different from patient's)*: ____

City: ___________________________ State/Province: ___________________ Zip/Postal Code: _______________________

Employer: _______________________________ Insurance Coverage for Orthodontic Treatment? Yes No

***It is your responsibility to inform us if your insurance needs to be pre-authorized before the appliances are placed.**

Primary Policy Holder's Name: ______________________________ S.S.N/S.I.N.: _________________

Birth Date: _________________ Employed By: ____

Dental Insurance Company: _________________________________

Secondary Policy Holder's Name: ____

Birth Date: _________________ Employed By: ____

Dental Insurance Company:____

For the following questions circle yes, no or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

MEDICAL HISTORY

yes no dk/u Birth defects or hereditary problems?
Describe: ____________________
yes no dk/u Bone fractures, any major accidents?
Describe: ____________________
yes no dk/u Rheumatoid or arthritic conditions?
yes no dk/u Endocrine or thyroid problems?
yes no dk/u Kidney problems?
yes no dk/u Diabetes?
yes no dk/u Cancer, tumor, radiation treatment or chemotherapy?
yes no dk/u Stomach ulcer or hyperacidity?
yes no dk/u Polio, mononucleosis, tuberculosis, pneumonia?
yes no dk/u Problems of the immune system?
yes no dk/u AIDS or HIV positive?
yes no dk/u Hepatitis, jaundice or liver problem?
yes no dk/u Fainting spells, seizures, epilepsy or neurological problem?
yes no dk/u Mental health disturbance or depression?
yes no dk/u Vision, hearing, tasting or speech difficulties?
yes no dk/u Loss of weight recently, poor appetite?
yes no dk/u History of eating disorder (anorexia, bulimia)?
yes no dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?
yes no dk/u High or low blood pressure?
yes no dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
yes no dk/u Chest pain, shortness of breath or swelling ankles?
yes no dk/u Skin disorder?
yes no dk/u Frequent headaches, colds or sore throats?
yes no dk/u Eye, ear, nose or throat condition?
yes no dk/u Hay fever, asthma, sinus trouble or hives?
yes no dk/u Tonsil or adenoid conditions?
yes no dk/u Osteoporosis? If yes, list medications: ____________________
____

Allergies or reactions to any of the following:

yes no dk/u Local anesthetics (Novocaine or Lidocaine)
yes no dk/u Aspirin
yes no dk/u Ibuprofen (Motrin, Advil)
yes no dk/u Penicillin or other antibiotics
yes no dk/u Sulfa Drugs
yes no dk/u Codeine or other narcotics
yes no dk/u Metals (jewelry, clothing snaps)
yes no dk/u Latex (gloves, balloons)
yes no dk/u Vinyl
yes no dk/u Acrylic
yes no dk/u Animals
yes no dk/u Foods (specify) ____________________
yes no dk/u Other substances (specify)____________________
____

yes no dk/u Are you taking medication, nutrient supplements, herbal medications or non prescription medicine? If yes, please name them.

Medication ____________________ Taken for ____________________
Medication ____________________ Taken for ____________________
Medication ____________________ Taken for ____________________
Medication ____________________ Taken for ____________________
Medication ____________________ Taken for ____________________
Medication ____________________ Taken for ____________________
Medication ____________________ Taken for ____________________

yes no dk/u Do you currently have or ever had a substance abuse problem?
yes no dk/u Do you chew or smoke tobacco?
yes no dk/u Operations? Describe:____________________
yes no dk/u Hospitalized? Describe: ____________________
yes no dk/u Other physical problems or symptoms? Describe: ____________________
____
yes no dk/u Being treated by another health care professional?
For: ____________________
yes no dk/u Date of most recent physical exam? ____________________
yes no dk/u Do you have any other medical conditions that we should know about?
____

WOMEN ONLY

yes no dk/u Are you pregnant?
yes no dk/u Are you anticipating becoming pregnant?

DENTAL HISTORY

Now or in the past, have you had:

yes no dk/u Permanent or "extra" (supernumerary) teeth removed?
yes no dk/u Supernumerary (extra) or congenitally missing teeth?
yes no dk/u Chipped or otherwise injured primary (baby) or permanent teeth?
yes no dk/u Teeth sensitive to hot or cold; teeth throb or ache?
yes no dk/u Jaw fractures, cysts or mouth infections?
yes no dk/u "Dead teeth" or root canals treated?
yes no dk/u Bleeding gums, bad taste or mouth odor?
yes no dk/u Periodontal "gum problems"?
yes no dk/u Food impaction between teeth?
yes no dk/u "Gum boils:, frequent canker sores or cold sores?
yes no dk/u Thumb, finger, or sucking habit? Until what age _________?
yes no dk/u Abnormal swallowing habit (tongue thrusting)?
yes no dk/u Mouth breathing habit, snoring or difficulty in breathing?
yes no dk/u Tooth grinding or jaw clenching?
yes no dk/u Any pain, clicking or locking in jaw or ringing in the ears?
yes no dk/u Any pain or soreness in the muscles of the face or around the ears?
yes no dk/u Have you ever been treated for "TMD" of "TMJ" problems?
yes no dk/u Aware of loose, broken or missing restorations (fillings)?
yes no dk/u Any teeth irritating cheek, lip, tongue or palate?
yes no dk/u Concerned about spaced, crooked or protruding teeth?
yes no dk/u Aware or concerned about under or over developed jaw?
yes no dk/u Any relative with similar tooth or jaw relationships?
yes no dk/u Any wisdom tooth problems?
yes no dk/u Had peridontal (gum) treatment?
yes no dk/u Had any serious trouble associated with any previous dental treatment?
yes no dk/u Been under another dentist's care?
Specialist ______________________________
Other ______________________________
yes no dk/u Ever had a prior orthodontic examination or treatment?
yes no dk/u Would you object to wearing orthodontic appliances (braces) should they be indicated?

How often do you brush: ______________________ Floss: ______________________

What is your primary concern? Why are you here? ____

____

Orthodontic consultation prompted by: Self Dentist Mother Father Sibling Physician Friend Other (Specify):____

I have read and understand the above questions. I will not hold Dubuque Orthodontic Associates, P.C. responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

NOTE: EXAM APPOINTMENTS ARE NO CHARGE.
IF DIAGNOSTIC RECORDS (INCLUDING X-RAYS) ARE TAKEN AND TREATMENT IS NOT PURSUED, THERE WILL BE A CHARGE OF $280.00

Signed: ____ Date Signed: ______________
(Patient)