New Patient Form: Adult Health History

Dubuque Orthodontic Associates

Patient's First Name: _____ M.I. ____ Last Name: _____
Birthdate: _____/_____/_____ Age: ____ Sex: Male Female I prefer to be called: _____
Cell Phone: (_____) _____ - _____
Email: _____
Patient's Address: _____
City: _____ State: _____ Zip/Postal Code: _____
Occupation: _____ Employer: _____
Name of Spouse/Closest Relative: _____ Phone (_____) _____ - _____
Relationship to you: _____
Address (if different than yours): _____
City: _____ State: _____ Zip/Postal Code: _____
First and Last Names of other family members treated here: _____
_____
Name of your dentist: _____ Date of last checkup: _____/_____/_____

Who is Financialy Responsible For This Account (if other than yourself)

First Name: _____ Last Name:_____
Address (if different than yours): _____
City: _____ State: _____ 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 or has a waiting period before the start of treatment*****

Primary Policy Holder's Name: _____ S.S.N./S.I.N.: _____
Birth Date: _____ Employed By: _____
Dental Insurance Company: _____
Secondary Policy Holder's Name: _____ S.S.N./S.I.N.: _____
Birth Date: _____ Employed By: _____
Dental Insurance Company: _____

How did you hear about us or who can we thank?

Please circle: dentist friend (_____) google search

What is your primary concern? What brings you to us? _____

Medical History (please circle yes, no, or dk for "don't know")

Yes No dk Birth defects or hereditary problems? _____
Yes No dk Heart/cardiovascular problem? _____
Yes No dk Repaired/unrepaired heart defects? _____
Yes No dk Cancer, radiation, or chemotherapy? _____
Yes No dk Arthritic conditions? _____
Yes No dk Osteoporosis or other bone disorder? _____
Yes No dk Stomach ulcers, GERD, or hyperacidity? _____

Yes No dk Immune system problems? _____

Yes No dk Diabetes? _____

Yes No dk History of epilepsy, seizures, fainting? _____

Yes No dk Eye, ear, nose, or throat condition? _____

Yes No dk AIDS/HIV positive? _____

Yes No dk Polio, mononeucleosis, tuberculosis, pneumonia? _____

Yes No dk Tobacco/Alcohol use? _____

Yes No dk Operations/hospitalized? _____

Yes No dk Any other past/current conditions that we should know? _____

Allergies or reactions to any of the following:

Yes No dk Local anesthetics (Novocaine or Lidocaine)

Yes No dk Ibuprofen (Motrin, Advil)

Yes No dk Metals (jewelry, clothing snaps)

Yes No dk Other (specify) _____

Yes No dk Latex (gloves, balloons, etc.)

Yes No dk Penicillin or other antibiotics

Yes No dk Acrylics

Please list medications, supplements, or nonprescriptive medicine and what they are taken for:

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Females Only

Yes No dk Is the patient pregnant? If yes, please provide due date: _____/_____/_____

Yes No dk Started monthly periods? If so, approximately when: _____

Dental History

Yes No dk Injuries to face, teeth, lips? _____

Yes No dk Extra or missing teeth? _____

Yes No dk Jaw pain or soreness in facial muscles? _____

Yes No dk History of thumb or finger sucking habit? Until what age? _____

Airway History

Yes No dk Clenching or grinding teeth? _____

Yes No dk Mouth breathing habit, snoring, or difficulty breathing? _____

Yes No dk Tonsils and/or adenoids Removed? Approximate Date: _____/_____/_____

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 FREE OF CHARGE. DIAGNOSITC RECORDS (INCLUDING X-RAYS, SCANS, PHOTOS) WILL INCLUDE A CHARGE OF $200.00 AT THE RECORDS VISIT COUNTED AS A DEPOSIT TOWARDS TREATMENT.

Signed: _____ Date Signed: _____/_____/_____