Str8rsmiles

Patient Health History Form

Today's Date: _____

Name:_____
Last First MI

Gender: □ Male □ Female Birthdate:_____ Age: _____

Home Address:_____

□ Single □ Married □ Divorced □ Widowed □ Separated

Home Phone: _____Work Phone: _____Cell:_____

Driver License Number:_____

Email Address:_____

Employer:_____Address:_____

Occupation: _____How long have you worked there?_____

What is the best time to reach you? _____Other family members seen by us?_____

Dentist Name: _____□ Previous □ Present Date last visit?_____

Person Responsible for Account: _____

Spouse Information
Name: _____ Employer: _____
Primary Phone Number: _____Social Security Number: _____
Birthdate: _____ Driver License Number: _____

Relative or friend not living with you:
Name: _____ Relation: _____
Home Phone: _____Work Phone: _____Cell:_____

Orthodontic Insurance
Primary: _____ Orthodontic Coverage? □ Y □ N Dental Coverage? □ Y □ N
Insurance Company Name: _____
Insurance Company Address:_____
Insurance Company Phone Number: _____
Insured Name:_____ Relation:_____Insured Birthdate:_____
Group Number: _____ Insured ID Number:_____
Insured Employer:_____ Employer Address:_____

Aberdeen
1010 Beards Hill Rd Suite G
410-272-7970

Edgewood
1401 Pulaski Highway Suite V
410-679-2523

Elkridge
8182 Lark Brown Rd
410- 799-8194

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Secondary Insurance:

Primary: _____ Orthodontic Coverage? □ Y □ N Dental Coverage? □ Y □ N

Insurance Company Name: _____

Insurance Company Address:_____

Insurance Company Phone Number: _____

Insured Name:_____ Relation:_____Insured Birthdate:_____

Group Number: _____Insured ID Number:_____

Insured Employer:_____

Employer Address:_____

Payment is due in full at the time of treatment unless prior arrangements have been approved by our office.

If this office accepts insurance, I understand that I am responsible for payment of services and paying any co-payment that my insurance does not cover, including deductible. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature Date

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Patient Health History Form

Medical History

Do you have a personal physician? □ Y □ N Physician's Name:_____

Physician's Phone Number:_____ Date of last visit:_____

Your current health is □ Good □ Fair □ Poor

Are you currently under the care of a physician? □ Y □ N

Please explain:_____

Do you smoke or use tobacco in any other form? □ Y □ N

Have you had any metal rods, pins, or implants? □ Y □ N

Are you taking any prescription/ over the counter drugs? □ Y □ N

Please list each one:_____

Have you ever taken Fosamax or any bisphosphonate? □ Y □ N

Have you ever taken Phen-Fen (Redux or Pondimin)? □ Y □ N

If so, when?

WOMEN: Are you taking birth control pills? □ Y □ N

Are you pregnant? □ Y □ N Week Number:_____ Are you nursing? □ Y □ N

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

Y N Abnormal Bleeding/ Hemophilia	Y N Herpes/ Fever Blisters
Y N Aids	Y N HIgh Blood Pressure
Y N Alcohol/ Drug Abuse	Y N HIV
Y N Anemia	Y N Hospitalized for any reason
Y N Arthritis	Y N Kidney Problems
Y N Artificial Bones/ Joints/ Valves	Y N Liver Disease
Y N Asthma	Y N Low Blood Pressure
Y N Blood Transfusion	Y N Lupus
Y N Cancer/ Chemotherapy	Y N Mitral Valve Prolapse
Y N Colitis	Y N Pacemaker
Y N Congenital Heart Defect	Y N Psychiatric Problems
Y N Diabetes	Y N Radiation Treatment
Y N Difficulty Breathing	Y N Rheumatic/ Scarlet Fever
Y N Emphysema	Y N Seizures
Y N Epilepsy	Y N Shingles
Y N Fainting Spells	Y N Sickle Cell Disease/ Traits
Y N Frequent Headaches	Y N Sinus Problems
Y N Glaucoma	Y N Stroke
Y N Hay Fever	Y N Thyroid Problems
Y N Heart Attack/ Surgery	Y N Tuberculosis (TB)
Y N Heart Murmur	Y N Ulcers
Y N Hepatitis	Y N Venereal Disease

Please list any other serious medical conditions that you have had:_____

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Penicillin
Y N Codeine	Y N Jewelry/ Metals	Y N Tetracycline
Y N Dental Anesthetics	Y N Latex	Y N Other

List any other drug or materials allergies:_____

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Our Office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

Medical History Update

Has there been any change in your health status since your last visit? □ Y □ N
If Yes, please explain:_____

Patient Signature:_____

Doctor Signature:_____

Dental History

What would you like orthodontics to accomplish?_____
Have you ever had or been evaluated for orthodontic treatment? □ Y □ N
Have you ever had a serious or difficult problem associated with any previous dental work? □ Y □ N
Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/ TMD)? □ Y □ N
Your current overall health is: □ Good □ Fair □ Poor
Do you still have wisdom teeth? □ Y □ N
Have you ever had an injury to your: □ Mouth □ Teeth □ Chin
Do you have any speech problems? □ Y □ N
Do you breath through your mouth? □ While Awake □ While Asleep
Do you have any missing or extra permanent teeth? □ Y □ N
Do you like your smile? □ Y □ N If not, what would you change?_____

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

_____

Signature Date

Office Use Only

I verbally reviewed the medical/dental information with the patient need herein.

Initials: _____

Date: _____

Doctor's Comments _____

_____

_____

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