McSweeney Orthodontics

ADULT HEALTH HISTORY

Welcome to our office!

Patient Name: _____

Prefer to be addressed as:_____ Sex: M F

Date of Birth: _____ /_____/_____ Age _____ Social Sec # _____ - ____ - _____

Home Phone #:_____ Work Phone #:_____

Cell#:_____ □ √ if you want TEXT appointment reminders Email for appointment reminders: _____

Patient's Address: _____
Street City State Zip

Occupation: _____ Employed by: _____

Circle Marital Status: Single Married Separated Divorced Widowed

Spouse's Name: _____ Employed by: _____

Spouse's Occupation: _____ Spouse's Work Phone #: _____

Patient's Dentist: _____ Date of Last Exam: __/__/___

Patient's Physician: _____ Date of Last Exam: __/__/___

Name (s) of other family members seen in our office: _____

Responsible Party Information

Person responsible for account: □ Self □ Spouse □ Other _____

Primary Insurance Co:
Dental Insurance Co:_____Group #:_____Ortho Coverage: Y N
Insured's Name: _____ID#: _____Birth Date: ____/____/__

Secondary Insurance Co:
Dental Insurance Co:_____Group #:_____Ortho Coverage: Y N
Insured's Name: _____ID#: _____Birth Date: ____/____/____

Other Insurance Information: _____

Patient's Dental History

What are the main concerns you would like orthodontics (braces) to accomplish? _____
_____
With what aspect of orthodontic treatment are you most concerned? ____Quality _____ Cost _____Discomfort _____Time
Y N Has an orthodontist been consulted previously? If yes, please list name of orthodontist _____ and date of consultation: _____
Has there ever been any orthodontic treatment for any other member of your family? Y N Children: (Dr. _____)
Spouse (Dr. _____) Other family members (Dr. _____) Were you satisfied with the results? Y N
Y N Have there been any injuries to your face, mouth or teeth? _____
Y N Have you been informed of any missing or extra permanent teeth? _____
Y N Are you aware of any sores, lumps or irritated areas in the mouth? _____
Y N Do you play a musical instrument? Please list: _____
Y N Do you have any speech problems? _____
Y N Are you concerned about the appearance of your teeth? _____
Y N Is there anything that you would like to change about your smile? _____
Y N Do you brush daily?
Y N Do you floss daily?
Y N Thumb / Finger habit? Y N Lip sucking/ biting? Y N Nail biting?
Y N Any popping, clicking or jaw pain? Y N Clenching / Grinding Teeth?

Patient's Medical History

Please describe your current physical health: ☐ Good ☐ Fair ☐ Poor
Please list all drugs that you are currently taking: _____
_____
Please list all drugs to which you are **allergic:** _____
_____
Y N Are you currently under the care of a physician? _____
Y N Have you had tonsils and/ or adenoids removed? Age: _____
Y N Do you have any history of major illness? _____
Y N Have you ever been advised by a physician to take an antibiotic prior to any dental treatments?
Y N Have you ever received IV bisphosphonates such as Zometa (Zoledronate) or Pamidronate (Aredia)?
If treated, please list the dates that bisphosphonates therapy was started and stopped: _____
Y N Have you ever taken oral bisphosphonates such as Fosamax, Actonel or Boniva?
If treated, please list the dates that oral bisphosphonates therapy was started and stopped: _____
WOMEN: Are you pregnant or considering pregnancy in the next 2 years? Y N Are you nursing? Y N
Are you currently taking medication for Birth Control? Y N

Please circle Y or N regarding treatments for any of the following:

Y N Tuberculosis
Y N Endocarditis
Y N Heart Condition
Y N Heart Pacemaker
Y N Heart Angina
Y N Heart Attack (Coronary)
Y N Mitral Valve Prolapse
Y N Congenital Heart Disease
Y N Artificial Heart Valve
Y N Heart Surgery (date_____)
Y N Heart Murmur
Y N Rheumatic Fever
Y N Prosthetic (artificial) joint
Y N X-Ray/Radiation (Cancer)Therapy
Y N AIDS or HIV Positive
Y N Diabetes

Y N Respiratory Lung Disease
Y N High Blood Pressure
Y N Hepatitis (type:)
Y N Venereal Disease
Y N Herpes (oral cold sores)
Y N Blood Disorders/Bleeding Problems
Y N Inflammatory Rheumatism
Y N Arthritis
Y N Ulcers
Y N Stroke
Y N Anemia
Y N Asthma
Y N Epilepsy
Y N Glaucoma
Y N Fainting Spells

Y N ADD
Y N Kidney Trouble
Y N Liver Disease
Y N Psychiatric Treatment
Y N Drug Addiction
Y N Headaches
Y N Jaw Clicking
Y N Allergies
Y N Allergies to Metal
Y N Allergies to Latex
Y N Jaw Pain
Y N Tonsilitis
Y N Emotional Problems
Y N Other: _____
_____

I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct. THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE INFORMATION NOT DISCLOSED. I grant authority to the Doctor and Staff to perform all procedures and treatments in my best interest. I understand that where appropriate, Credit Bureau reports may be obtained. I authorize the Orthodontist to share pertinent treatment information with collaborating dentists and specialists. Records sent to non- collaborating offices will be charged at $100 each. I authorize the billing of insurance for treatment procedures when appropriate.

Signature of Patient: _____Date: _____
Signature of Orthodontist: _____Date: _____

Annual Update: Date: _____ Initials: _____
Date: _____ Initials: _____
Date: _____ Initials: _____