Adult Health History Form

Date ________________

Patient's name ______________________________ Date of birth ____________ O Male O Female
LAST FIRST MI

Address ______________________________ Phone ______________________________
STREET CITY STATE ZIP

Cell phone ______________________________ Email ______________________________

Employer ______________________________ Occupation ______________________________

Work address ______________________________ Work phone ______________________________
STREET CITY STATE ZIP

Insurance Co. ______________________________ SSN or ID No. ______________________________

Insurance Co. address ______________________________
STREET CITY STATE ZIP

Insurance phone ______________________________ Group No. ______________________________

Patient's dentist ______________________________ Patient's physician ______________________________

Who referred you to our office? ______________________________

Spouse's Information

Spouse's name ______________________________ Date of birth ______________________________
LAST FIRST MI

Employer ______________________________ Occupation ______________________________

Work address ______________________________
STREET CITY STATE ZIP

Work phone ______________________________

Insurance Co. ______________________________ SSN or ID No. ______________________________

Insurance Co. Address ______________________________
STREET CITY STATE ZIP

Insurance Phone ______________________________ Group No. ______________________________

Medical History

Are you in good health? O Yes O No

Do you have any history of major illness? O Yes O No

Have you ever been treated for an illness? O Yes O No

Check any of the following for which you have been treated:

- O Diabetes
- O Pneumonia
- O Heart trouble
- O Rheumatic fever
- O Bone disorder
- O Herpes
- O Anemia
- O Epilepsy
- O Asthma
- O Kidney involvement
- O Tuberculosis
- O AIDS/HIV
- O Prolonged bleeding
- O Fainting/dizziness
- O Nervous disorders
- O Liver involvement
- O Endocrine problems
- O Other: ______________________________
- O If none of the above, please initial ____

Are you prone to the following? O Yes O No
- O Colds?
- O Sore throats?
- O Ear infections?

Have your tonsils/adenoids been removed? O Yes O No
If so, at what age?_______

List any drugs/medications you are taking and for what reasons:______________________________
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(If none, please write "None" in blank above, and initial.) ____

List any allergy or drug sensitivity that you have:
____
____

(If none, please write "None" in blank above, and initial.) ____

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Douglasville, GA 30135
P: 770.942.4100
F: 770.942.4945

4720-7 Jonesboro Rd.
Union City, GA 30291
P: 770.969.6444
F: 770.969.7008

Dental History

Have there been any injuries to your face/mouth/teeth? O Yes O No

Do you have any speech problems? ______________ O Yes O No

Are you a mouth-breather? O Yes O No
While awake? O Yes O No
While asleep? O Yes O No

Do you have any missing teeth? O Yes O No

Do you have any extra permanent teeth? O Yes O No

Has an orthodontist been consulted? O Yes O No

Reason for consultation: ______________________________

____

I have read and I understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form.

I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any later changes to this history record or medical/dental status.

We will discuss your treatment with parents/legal guardians/person(s) financially responsible for your treatment/referring doctor/dentist for the furtherment of your treatment.

______________________________ ______________
Signature Date

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

______________________________ ______________
Signature Date

Medical History Updates or Changes

Date: ______________

Comments: ______________

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Signature: ______________

Date: ______________

Comments: ______________

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Signature: ______________

Date: ______________

Comments: ______________

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Signature: ______________

Thank you for filling out this form completely. It will enable us to provide you with better orthodontic care.