ALBANY BRACES

Adult Medical History Form

PATIENT INFORMATION **PLEASE PRINT (*BLACK/BLUE INK*) **

PATIENT'S FULL LEGAL NAME:_____ DOB:_____ SSN#_____

STREET ADDRESS:_____CITY/STATE/ZIP:_____

Preferred Name: _____ Assigned Sex at Birth _____

Preferred Pronouns (if different than Assigned Sex at Birth)_____

If student, name of school/college:_____ Grade _____

Employed by_____ Occupation_____

Length of employment_____ Work Address _____Work #_____

Parent/Guardian or Spouse Name_____ Marital status_____

Notify in case of emergency_____ Phone #_____

Whom may we thank for referring you to our office? _____

Siblings or Immediate Family Members that received treatment in this office:	

CONTACT INFORMATION

We would like to send you appointment reminders, information about treatment, payment, insurance and other communications. ***Please tell us how you would like us to communicate with you.***

HOME PHONE:_____	WORK PHONE:_____
CELL PHONE:_____	EMAIL :_____

☐ **By checking this box, I consent to the following: The practice or its service provider may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of auto dialing.** ***This is optional and not required to receive care at our office.***

FINANCIAL INFORMATION

Person(s) Responsible for Account _____

Relation to Patient _____ Birthdate _____ Social Security #_____

Address (if different from patient) _____Marital Status _____

Employed by_____ Occupation_____

Length of Employment_____ Work Address _____Work #_____

I, _____, hereby authorize and consent to any x-rays and examination rendered under the direct or indirect supervision of the orthodontist as they may deem necessary. I also understand this office may request pertinent medical, dental and financial history related to the anticipated treatment. This authorization will remain in effect until cancelled by writing.

Signature:_____ Date:_____

INSURANCE INFORMATION

Do you have orthodontic insurance coverage?	**Y / N**	**If YES, fill out the ADA Dental Claim Form.**

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DENTAL HISTORY

PATIENT'S DENTIST:_____	DATE OF LAST VISIT:_____ X-RAYS TAKEN: Y / N
DENTIST'S ADDRESS:_____	ANY DENTAL CONCERNS?
ANY PRIOR ORTHODONTIC TREATMENT: Y / N	
ORTHODONTIST:_____	**ARE YOU UNDER THE CARE OF ANY OTHER DENTAL SPECIALIST?** **Y / N**
EXPLAIN:	SPECIALIST'S NAME:_____
PAST FACIAL, HEAD OR NECK TRAUMA: Y / N	EXPLAIN:
PAST DENTAL TRAUMA: Y / N	SPEECH THERAPY: Y / N

How often do you brush your teeth?			Have you ever been told you have TMD?	Y	N
Do you floss regularly?	Y	N	Do you snore?	Y	N
Do your gums bleed?	Y	N	Do you ever clench your teeth?	Y	N
Have you had unusual bleeding with previous extractions surgery?	Y	N	Do you have any pain or discomfort, in the jaw-joint, face or neck?	Y	N
Can you chew on both sides of your mouth?	Y	N	Is there a history of gum disease?	Y	N
Are your teeth painful?	Y	N	Are you aware of any gum recession?	Y	N
Are you aware of your jaws making clicking, popping or cracking noises?	Y	N	Have you ever had periodontal treatment?	Y	N

HABITS

THUMB SUCKING	Y	N	MOUTH BREATHER	Y	N
FINGER SUCKING	Y	N	USE OF TOBACCO	Y	N
NAIL BITTER	Y	N	OTHER:		

HEALTH HISTORY

PATIENT'S PHYSICIAN:	PHYSICIAN'S PHONE:
ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE: Y / N	HOSPITALIZED IN THE PAST 3 YEARS: Y / N
REASON(S):	CURRENT MEDICATION(S) OR TREATMENT DRUGS:
Do you have any mental illness or developmental disability that requires special attention?	
ALLERGIES TO ANY DRUGS OR MEDICINE? Y (PLEASE LIST) / N	Height_____ Weight_____

Have you been in any other institutions (weight reduction, drug or alcohol treatment, psychiatric, or other) in the past 3 years?	Y	N	Do you occasionally use or take recreational drugs?	Y	N
Have you had a blood transfusion in the past 3 years?	Y	N	Have you had prolonged coughing or coughed up blood?	Y	N
Do you perspire excessively at night?	Y	N	Have you ever been tested for hepatitis or AIDS?	Y	N
Do you have persistent diarrhea or recent weight loss?	Y	N	*Results were: Negative (no virus) ____ Positive (virus present) ____*		
Have you ever had damage or artificial heart valves, including heart murmur, rheumatic heart disease, or scarlet fever?	Y	N	Have you had canker sores, cold sores, fever blisters or other sores on your lips, tongue, gums, genitals or body in the past 3 years?	Y	N
Do you have a purplish rash or persistent purplish bruise(s)?	Y	N	Do you require any pre-medication for dental or other treatment?	Y	N
Are you pregnant? (if applicable)	Y	N	*Please explain:*		

Check any of the following which you have had or now have (provide date to the left)

☐ _____ AIDS	☐ _____ cardiovascular disease	☐ _____ heart trouble	☐ _____ organ transplant
☐ _____ allergies	☐ _____ chicken pox	☐ _____ hepatitis	☐ _____ osteoporosis
☐ _____ anemia	☐ _____ chronic cough	☐ _____ herpes	☐ _____ psychiatric treatment
☐ _____ arthritis	☐ _____ congenital heart lesions	☐ _____ high blood pressure	☐ _____ shortness of breath
☐ _____ artificial heart valves	☐ _____ cytomegalovirus (CMV)	☐ _____ immune disorders	☐ _____ sinus trouble
☐ _____ artificial joints	☐ _____ diabetes	☐ _____ jaundice	☐ _____ stroke
☐ _____ asthma	☐ _____ dizziness, fainting spell	☐ _____ kidney treatment	☐ _____ tuberculosis
☐ _____ bacteria endocarditis	☐ _____ epilepsy	☐ _____ measles or mumps	☐ _____ sexually transmitted diseases
☐ _____ cancer treatment	☐ _____ glaucoma	☐ _____ mitral valve prolapse	☐ _____ chemotherapy
☐ _____ cardiac pacemaker	☐ _____ heart murmur	☐ _____ mononucleosis	☐ _____ radiation therapy