TRAN ORTHODONTICS

— SPECIALIST IN BRACES —

Adult Patient Health History Form

Today's Date: ______/______/______

Patient Information

Full Name: ____________________ Nick Name: ____________ Sex: ☐ Male ☐ Female

First Last Middle Initial

Home Address: ______________________________ D.O.B. ____/____/____

Street Apt./Condo #

Age: ____________

____

City State Zip Code

SSN: ____________

Cell Phone: ____________________ Home Number: ____________________

Email: ____________________

When and where is the best time to reach you? ____________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer: ____________________ Occupation: ____________________ # of Years ______

General Dentist: ____________________ Last Visit: ____________ Contact Number: ____________

Whom may we Thank for referring you? ____________________

Please list any family members who have receieved treatment in our office: ____________________

Spouse Information

His/Her Name: ____________________ D.O.B. ____/____/____ SSN: ____________

Employer: ____________________ Work Number: ____________ Ext: ______

Person Responsible for Account

Name: ____________________ ☐ Same as Above

Billing Address: ______________________________ D.O.B. ____/____/____

Street Apt./Condo #

______________________________ SSN: ____________

City State Zip Code

Employer: ____________________ Relationship: ____________________

Primary Number: ____________________ Home Number: ____________________

Cell Number: ____________________ Work Number: ____________ Ext: ______

Othodontic Insurance

Orthodontice Coverage: ☐ Yes ☐ No Dental Coverage: ☐ Yes ☐ No

Insurance Company Name: ______________________________

Insurance Company Address: ______________________________

Street

____

City State Zip Code

Insurance Company Phone Number: ____________________ Group Number ____________________

Insured's Name: ____________________ Relationship: ____________________

Insured's Birthdate: ______/______/______ Insured's SSN: ____________________

Insured's Employer: ______________________________

Emergency Information

His/her Name: ______________________ Relationship: ______________

Home Number: ______________ Work Number: ______________

Medical History

Have you ever had any of the following problems?

☐ Yes ☐ No	Abnormal Bleeding	
☐ Yes ☐ No	Anemia	
☐ Yes ☐ No	Artifical Bones/ Joints/ Vales	
☐ Yes ☐ No	Asthma / Arthritis	
☐ Yes ☐ No	Blood Transfusion	
☐ Yes ☐ No	Cancer / Chemotherapy	
☐ Yes ☐ No	Congenital Heart Defect	
☐ Yes ☐ No	Diabetes	
☐ Yes ☐ No	Difficulty Breathing	
☐ Yes ☐ No	Drug / Alcohol Abuse	
☐ Yes ☐ No	Emphysema	
☐ Yes ☐ No	Epilepsy / Seizures / Fainting	
☐ Yes ☐ No	Fever Blisters / Herpes	
☐ Yes ☐ No	Glaucoma	
☐ Yes ☐ No	Heart Attact / Stroke	
☐ Yes ☐ No	Heart Murmur	
☐ Yes ☐ No	Heart Surgery / Pacemaker	
☐ Yes ☐ No	Hemophilia	
☐ Yes ☐ No	Hepatitis	
☐ Yes ☐ No	High / Low Blood Pressure	
☐ Yes ☐ No	HIV+ / AIDS	
☐ Yes ☐ No	Hospitalized for Any Reason	
☐ Yes ☐ No	Kidney Problems	
☐ Yes ☐ No	Mitral Valve Prolapse	
☐ Yes ☐ No	Psychiatric Problems	
☐ Yes ☐ No	Radiation Treatment	
☐ Yes ☐ No	Rheumatic / Scarlet Fever	
☐ Yes ☐ No	Severe / Frequent Headaches	
☐ Yes ☐ No	Shingles	
☐ Yes ☐ No	Sickle Cell Disease / Traits	
☐ Yes ☐ No	Sinus Problems	
☐ Yes ☐ No	Tuberculosis	
☐ Yes ☐ No	Ulcers / Colitis	
☐ Yes ☐ No	Veneral Disease	

Are you allergic to any of the following?

☐ Yes ☐ No	Aspirin	☐ Yes ☐ No	Dental Anesthetics	☐ Yes ☐ No	Penicillin
☐ Yes ☐ No	Codeine	☐ Yes ☐ No	Erythromycin	☐ Yes ☐ No	Tetracycline
☐ Yes ☐ No	Latex	☐ Yes ☐ No	Metals/ Plastics	☐ Yes ☐ No	Other

Dental History

What are the main concerns that you would like orthodontics to accomplish?

____

____

Have you ever had or been evaluated for orthodontic treatment? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ /TMD)? ☐ Yes ☐ No

Your current dental health is? ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No ☐ Mouth ☐ Teeth ☐ Chin

Gums ever bleed? ☐ Yes ☐ No

Do you have any speech problems? ______________

Do you generally breathe through your mouth? ☐ Yes ☐ No If yes: While Awake? While Alseep?

Do you have any missing or extra permanent teeth? ☐ Yes ☐ No

Have you ever taken Phen-Fen? (also known as Redux or Pandimin) ☐ Yes ☐ No If yes, when? ______________

Do you smoke or use tobacco of any form? ☐ Yes ☐ No

I understand that the information I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that 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 informal consent. I understand that if the office accept my insurance that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

____

Signature Date