STURGILL ORTHODONTICS

ADULT HEALTH FORMS

PERSONAL INFORMATION

NAME _____

☐ MR. ☐ MRS. ☐ MS. ☐ DR.

PREFERRED NAME: _____ ☐ MALE ☐ FEMALE

BIRTHDATE: ____/____/____ AGE: ___ SSN# _____

HOME ADDRESS: _____

_____

HOME: (___)_____ CELL: (___)_____

WORK: (___)_____ EXT: _____

EMAIL: _____

PREFERRED CONTACT: ☐ HOME ☐ CELL ☐ WORK ☐ EMAIL

EMPLOYER: _____

HOW LONG THERE?: _____ OCCUPATION: _____

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

IF MARRIED, SPOUSE'S NAME: _____

SPOUSE'S NUMBER: _____

DENTAL INSURANCE

ORTHODONTIC BENEFIT? ☐ YES ☐ NO ☐ UNSURE

INSURANCE CO. NAME: _____

INSURANCE CO. PHONE NUMBER: (___)_____

GROUP POLICY NUMBER: _____

Secondary Dental Insurance

ORTHODONTIC BENEFIT? ☐ YES ☐ NO ☐ UNSURE

INSURANCE CO. NAME: _____

INSURANCE CO. PHONE NUMBER: (___)_____

GROUP POLICY NUMBER: _____

If the primary insured person for either insurance(s) is someone other than you, please provide the following:

INSURED'S NAME: _____

INSURED'S RELATION: _____

INSURED'S BIRTHDATE: ___/____/____ SSN: _____

INSURED'S EMPLOYER: _____

ARE YOU RESPONSIBLE FOR THE ACCOUNT? ☐ YES ☐ NO

IF NO, PLEASE NAME: _____

MEDICAL HISTORY

DO YOU HAVE A PRIMARY CARE PHYSICIAN? ☐ YES ☐ NO

PHYSICIAN'S NAME: _____

PHONE: (___)_____ LAST VISIT: _____

YOUR CURRENT PHYSICAL HEALTH IS: ☐ GOOD ☐ FAIR ☐ POOR

HEIGHT: _____ WEIGHT: _____

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

DO YOU SMOKE OR USE TOBACCO IN ANY FORM? ☐ YES ☐ NO

DO YOU USE RECREATIONAL DRUGS? ☐ YES ☐ NO

HAVE YOU HAD ANY METAL RODS, PINS, OR IMPLANTS? ☐ YES ☐ NO

PLEASE LIST ANY PRESCRIPTIONS OR OVER THE COUNTER DRUGS YOU TAKE AND THE REASON FOR MEDICATION:

_____

_____

_____

HAVE YOU EVER TAKEN FOSAMAX, ACTONEL, BONIVA, OR ANY OTHER FORM OF BISPHOSPHATE? ☐ YES ☐ NO

Please circle if you have or have had any of the following conditions:

Y N AIDS/HIV
Y N Alcohol/Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Joints/Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Colitis or Cold Sores
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack/Surgery
Y N Heart Murmur
Y N Hemophilia/Blood Disorder
Y N Hepatitis
Y N Herpes/Fever Blisters
Y N High Blood Pressure
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Problems
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease/Trait
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

OTHER MEDICAL CONDITION(S): _____

_____

MEDICAL HISTORY

DO YOU HAVE ANY ALLERGIES? ☐ YES ☐ NO IF YES, PLEASE CIRCLE FROM THE LIST BELOW OR WRITE IN THE SPACE PROVIDED:

Aspirin Metals/Nickel Advil/Ibuprofen Penicillin Latex Codeine Dogs

OTHER ALLERGIES AND REACTIONS: _____

_____

_____

WOMEN ONLY:

ARE YOU PREGNANT? ☐ YES ☐ NO IF YES, WEEK NUMBER: _____ ARE YOU ON BIRTH CONTROL? ☐ YES ☐ NO

ARE YOU NURSING? ☐ YES ☐ NO ARE YOU PLANNING TO BECOME PREGNANT IN THE NEXT TWO YEARS? ☐ YES ☐ NO

DENTAL HISTORY

GENERAL DENTIST: _____

LAST VISIT: _____ REASON FOR VISIT: _____

OTHER DENTAL SPECIALISTS YOU SEE ROUTINELY (I.E. PERIODONTIST): _____

ORTHODONTIC HISTORY

LIST ANY CONCERNS YOU HAVE ABOUT YOUR SMILE AND/OR BITE:

_____

_____

_____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

OTHER FAMILY MEMBERS SEEN BY US: _____

HAVE YOU EVER HAD ORTHODONTIC TREATMENT? ☐ YES ☐ NO IF YES, PLEASE EXPLAIN: _____

Have you ever been evaluated by an orthodontist?	☐ YES	☐ NO	Have you ever been treated for TMJ/TMD?	☐ YES	☐ NO
Has anyone in your family had jaw surgery to correct their bite?	☐ YES	☐ NO	Do you experience discomfort/pain in your jaw joints?	☐ YES	☐ NO
History of facial birth defects or cleft palate?	☐ YES	☐ NO	Does your jaw routinely pop or click?	☐ YES	☐ NO
Have you ever been diagnosed with sleep apnea?	☐ YES	☐ NO	Has your jaw ever locked closed or open?	☐ YES	☐ NO
Have you ever been diagnosed with speech problems?	☐ YES	☐ NO	Do you have frequent headaches/migraines?	☐ YES	☐ NO
Do you commonly snore?	☐ YES	☐ NO	Do you wear a mouthguard at night?	☐ YES	☐ NO
Do you grind or clench your teeth?	☐ YES	☐ NO	Do you experience pain or ringing in your ears?	☐ YES	☐ NO
Have you ever had major trauma/injury to your face, jaw, teeth, or mouth?	☐ YES	☐ NO	Do you typically breathe through your (circle one)	MOUTH	NOSE

I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to Sturgill Orthodontics. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including records of examination, diagnosis, and treatment rendered, to my insurance company. 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 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 informed consent. I understand that Sturgill Orthodontics reserves the right to verify the credit status of patients and/or their parents prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services. Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, the ADA, and the AAO.

SIGNATURE: _____ DATE: _____

OFFICE USE ONLY

I HAVE VERBALLY REVIEWED THE MEDICAL/DENTAL INFORMATION WITH THE PATIENT NAMED HEREIN.

TC SIGNATURE/DATE: _____ DOCTOR SIGNATURE: _____