

# Medical Dental History Form for Adult Patients

## PATIENT

Date \_\_\_\_\_

Patient's last name \_\_\_\_\_ First name \_\_\_\_\_ Middle initial \_\_\_\_\_

Title Mr. Mrs. Ms. Miss. Dr. Other \_\_\_\_\_ I prefer to be called \_\_\_\_\_

Birth date \_\_\_\_\_ Sex  Male  Female Social Security # \_\_\_\_\_

Marital Status  Single  Married  Separated  Divorced  Widowed

Home address \_\_\_\_\_ City, State, Zip code \_\_\_\_\_

Home phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Work phone ( ) \_\_\_\_\_ - \_\_\_\_\_

Email Address(es) \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

## CLOSEST RELATIVE

Spouse or closest relatives name(s) \_\_\_\_\_

Title Mr. Mrs. Ms. Miss. Dr. Other \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address (if different than patient address) \_\_\_\_\_

Home Phone (if different) ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Work phone ( ) \_\_\_\_\_ - \_\_\_\_\_

## DENTIST

Patient's Dentist \_\_\_\_\_ Address, City, State \_\_\_\_\_

Last seen \_\_\_\_\_ Reason \_\_\_\_\_ Next appointment \_\_\_\_\_

Other dentists/dental specialists now being seen: Name \_\_\_\_\_ City, State \_\_\_\_\_

Reason \_\_\_\_\_

## PHYSICIAN

Patient's Physician \_\_\_\_\_ City, State \_\_\_\_\_

Last seen \_\_\_\_\_ Reason \_\_\_\_\_ Next appointment \_\_\_\_\_

Most recent physical exam \_\_\_\_\_

Other physicians/health care providers being seen now:

Name \_\_\_\_\_ City, State \_\_\_\_\_

Reason \_\_\_\_\_

Name \_\_\_\_\_ City, State \_\_\_\_\_

Reason \_\_\_\_\_

## GENERAL INFORMATION

What concerns you about your teeth? \_\_\_\_\_

Who suggested that you might need orthodontic treatment? \_\_\_\_\_

Why did you select our office? \_\_\_\_\_

Have you had any previous orthodontic treatment? Please describe. \_\_\_\_\_

Have any other family members been treated in this office? Please name them. \_\_\_\_\_

Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain. \_\_\_\_\_

## FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? \_\_\_\_\_

Address (if different than page 1) \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home phone (       ) \_\_\_\_\_ - \_\_\_\_\_ Cell phone (       ) \_\_\_\_\_ - \_\_\_\_\_ Email address(es) \_\_\_\_\_

Social Security # \_\_\_\_\_ Employer \_\_\_\_\_

## DENTAL INSURANCE

Primary policy holder's full name \_\_\_\_\_ Birth date \_\_\_\_\_

Social Security # \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address and phone (if not listed above) \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Insurance company \_\_\_\_\_ Group # \_\_\_\_\_ ID# \_\_\_\_\_

Does this policy have orthodontic benefits?  Yes  No  Don't Know

Secondary policy holder's full name \_\_\_\_\_ Birth date \_\_\_\_\_

Social Security # \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address and phone (if not listed above) \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Insurance company \_\_\_\_\_ Group # \_\_\_\_\_ ID# \_\_\_\_\_

Does this policy have orthodontic benefits?  Yes  No  Don't Know

## MEDICAL INSURANCE

Policy holder's full name \_\_\_\_\_

Insurance Company \_\_\_\_\_

**Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation.**

For the following questions, please mark yes, no, or don't know/understand (dk/u).

## MEDICAL HISTORY

**Now or in the past, have you had:**

Yes No DK/U

- Birth defects or hereditary problems?
- Bone fractures or major injuries?
- Any injuries to face, head, neck?
- Arthritis or joint problems?
- Endocrine or thyroid problems?
- Diabetes or low sugar?
- Kidney problems?
- Cancer, tumor, radiation treatment or chemotherapy?
- Stomach ulcer, hyperacidity, acid reflux?
- Immune system problems?
- History of osteoporosis?
- Gonorrhea, syphilis, herpes, sexually transmitted diseases?
- AIDS or HIV positive?
- Hepatitis, jaundice, or other liver problems?
- Polio, mononucleosis, tuberculosis, pneumonia?
- Seizures, fainting spells, neurologic problems?
- Mental health disturbance or depression?
- Vision, hearing, or speech problems?
- History of eating disorder (anorexia, bulimia)?
- High or low blood pressure?
- Excessive bleeding or bruising, anemia?
- Chest pain, shortness of breath, tire easily, swollen ankles?
- Heart defects, heart murmur, rheumatic heart disease?
- Angina, arteriosclerosis, stroke or heart attack?
- Skin disorder (other than common acne)?
- Do you eat a well-balanced diet?
- Frequent headaches or migraines?
- Frequent ear infections, colds, throat infections?
- Asthma, sinus problems, hayfever?
- Tonsil or adenoid condition?
- Do you frequently breathe through your mouth?

**Have you had allergies or reactions to any of the following?**

Yes No DK/U

- Local anesthetics (novocaine, lidocaine, xylocaine)
- Latex (gloves, balloons)
- Aspirin
- Metals (jewelry, clothing snaps)
- Penicillin
- Other antibiotics
- Ibuprofen (Motrin, Advil)
- Acrylics
- Plant pollens
- Animals
- Foods
- Other substances \_\_\_\_\_

## DENTAL HISTORY

**Now or in the past, have you had:**

Yes No DK/U

- Permanent or extra (supernumerary) teeth removed?
- Supernumerary (extra) or congenitally missing teeth?
- Chipped or injured primary or permanent teeth?
- Any sensitive or sore teeth?
- Bleeding gums, bad taste or mouth odor?
- Jaw fractures, cysts, infections?
- Any teeth treated with root canals or pulpotomies?
- "Gum boils," frequent canker sores or cold sores?
- History of speech problems or speech therapy?
- Difficulty breathing through nose?
- Food impaction between the teeth?
- Mouth breathing habit or snoring at night?
- Frequent oral habits (sucking finger, chewing pen, etc)?
- Teeth causing irritation to lip, cheek or gums?
- Abnormal swallowing (tongue thrust)?
- Tooth grinding or clenching?
- Clicking, locking in jaw joints?
- Soreness in jaw muscles or face muscles?
- Ringing in ears, difficulty in chewing or opening jaw?
- Have you ever been treated for "TMJ" or "TMD" problems?
- Any broken or missing fillings?
- Any serious trouble associated with previous dental treatment?
- Have you ever been diagnosed with gum disease or pyorrhea?
- Have you ever had an orthodontic consultation or treatment before now?

# PATIENT HEALTH INFORMATION

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements, that you take.

Medication \_\_\_\_\_ Taken for \_\_\_\_\_

Medication \_\_\_\_\_ Taken for \_\_\_\_\_

Medication \_\_\_\_\_ Taken for \_\_\_\_\_

Have you ever taken any medications to strengthen your bones? Please describe. \_\_\_\_\_

Do you take antibiotic pre-medication before any dental procedures? \_\_\_\_\_

Do you or have you ever had a substance abuse problem? \_\_\_\_\_

Do you chew or smoke tobacco? \_\_\_\_\_

Have you noticed any changes in your face or jaws? \_\_\_\_\_

Any other physical problems? \_\_\_\_\_

How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

Women: Are you pregnant?  Yes  No

Are you trying to become pregnant?  Yes  No

# FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following health problems? If so, please explain. \_\_\_\_\_

Bleeding disorders \_\_\_\_\_ Diabetes \_\_\_\_\_

Arthritis \_\_\_\_\_ Severe allergies \_\_\_\_\_

Unusual dental problems \_\_\_\_\_ Jaw size imbalance \_\_\_\_\_

Other family medical conditions? \_\_\_\_\_

# RELEASE AND WAIVER

**I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

# MEDICAL HISTORY UPDATES OR CHANGES

Changes \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Dental Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

Changes \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Dental Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

Changes \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Dental Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

**A Winning Smile Orthodontics  
Catherine Scheurer McDevitt**

**Acknowledgement of Receipt of Notice of Privacy Practices**

**\* You May Refuse to Sign This Acknowledgment\***

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

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**For Office Use Only**

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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# A Winning Smile

ORTHODONTICS

## HIPAA Authorization Form for Family Members and Friends

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I, \_\_\_\_\_, grant permission to Catherine Scheurer McDevitt DMD to disclose and release my protected health information (PHI) to the following persons:

| Name (s): | Relationship: |
|-----------|---------------|
| _____     | _____         |
| _____     | _____         |
| _____     | _____         |

**Health Information to be disclosed:**

- My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions dental and/or medical related)

**OR** My complete health record, as above, **with the exception** of the following information:

(Check as appropriate):

- Mental health records
- Communicable diseases (including HIV and AIDS)
- All dental records
- Other (please specify):  
\_\_\_\_\_

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (check one):

- All past, present, and future periods,
- OR** Until date or event: \_\_\_\_\_ unless I revoke it.  
(NOTE: You may revoke this authorization at any time by notifying us in writing.)

\_\_\_\_\_  
Printed Name of the Person Giving this Authorization

\_\_\_\_\_  
Signature of the Person Giving this Authorization

\_\_\_\_\_  
Date

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**Agreement to Receive Electronic Communication**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I agree that the dental practice may communicate with me electronically at the email address below.

**I am aware that there is some level of risk that third parties might be able to read unencrypted emails.**

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling:

**A Winning Smile Orthodontics at 614-888-8070**

Email Address (PLEASE PRINT CLEARLY):

\_\_\_\_\_  
@ \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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