CONFIDENTIAL

SmartSmiles Orthodontics – 315 Ray Thorington Rd. Montgomery, AL 36117 - www.SmartSmiles.com

American Association of Orthodontists MEDICAL DENTAL HISTORY FORM – Adult

1 Tell Us About Yourself

Date: _____

Name: _____
LAST FIRST MI

☐ Male ☐ Female I prefer to be called: _____

Address:_____ ☐Own ☐Rent

City_____ State_____ Zip _____

How long at address? _____ Birthdate: ___/___/___ Age: ____

Home # _____ Cell # _____

Cell Ph. Company (Sprint, Verizon, etc.):_____
(only if you would like text message appointment reminders)

Email:_____
(only if you would like email appointment reminders)

Occupation: _____ Work #: _____ Ext.: ____

Employer:_____ How Long? _____

Soc. Sec. #: _____

Dentist:_____ Phone _____

Physician(s): _____ Phone _____

Referred By:_____

Orthodontic Insurance Coverage? ☐ Yes ☐ No

Insurance Co. Name:_____

Insurance Co. Phone #: _____

Policy #: _____

Group #:_____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Employer: _____

2 Person Responsible for Account

(Complete this section only if someone other than the patient is financially responsible for account.)

Name: _____ Relation:_____

Address: _____ ☐Own ☐Rent

City _____ State_____ Zip _____

How long at address? _____ Birthdate: ___/___/_____

Soc. Sec. #:_____

Home # _____ Cell #_____

Work #: _____ Ext.: _____

Occupation:_____

Employer: _____

How long with this employer?_____

SmartSmiles Orthodontics

Engineered Smiles by Dr. Foch Smart

3 Notes

- Welcome you to our office! Our goal is to establish a partnership with you that will enable you to have a beautiful smile that lasts a lifetime.
- Orthodontic insurance information is requested for the purposes of helping you receive your insurance benefits. We will help you fully utilize your coverage as much as possible. However, the patient is ultimately responsible for payment of services.
- We respect your privacy. Questions about home ownership, length of employment, etc. are required only if orthodontic treatment will be financed through this office.

For the following questions circle **yes, no or don't know/understand (dk/u)**. The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

MEDICAL HISTORY Now or in the past, have you had:

yes no dk/u Birth defects or hereditary problems?
yes no dk/u Bone fractures, any major accidents?
yes no dk/u Rheumatoid or arthritic conditions?
yes no dk/u Endocrine or thyroid problems
yes no dk/u Kidney problems?
yes no dk/u Diabetes?
yes no dk/u Cancer, tumor, radiation treatment or chemotherapy?
yes no dk/u Stomach ulcer or hyperacidity?
yes no dk/u Polio, mononucleosis, tuberculosis, pneumonia?
yes no dk/u Problems of the immune system?
yes no dk/u AIDS or HIV positive?
yes no dk/u Hepatitis, jaundice, or liver problem?
yes no dk/u Fainting spells, seizures, epilepsy or neurological problem?
yes no dk/u Mental health disturbance or depression?
yes no dk/u Vision, hearing, tasting or speech difficulties?
yes no dk/u Loss of weight recently, poor appetite?
yes no dk/u History of eating disorder (anorexia, bulimia)?
yes no dk/u Excessive bleeding, bruising tendency, anemia or bleeding disorder?
yes no dk/u High or low blood pressure?
yes no dk/u Tired easily?
yes no dk/u Chest pain, shortness of breath or swelling ankles?
yes no dk/u **Cardiovascular problems (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects or rheumatic heart disease)?**
yes no dk/u Skin disorder?
yes no dk/u Do you have a well-balanced diet?
yes no dk/u Frequent headaches, colds or sore throat?

yes no dk/u Eye, ear, nose, throat condition?

yes no dk/u Hayfever, asthma, sinus trouble or hives?

yes no dk/u Tonsil, or adenoid conditions?

yes no dk/u Osteoporosis?

yes no dk/u **Do you take antibiotics before dental visits?**

Allergies or reactions to any of the following:

yes no dk/u Local anesthetics (Novocaine or Lidocaine)

yes no dk/u Aspirin

yes no dk/u Ibuprofen (Motrin, Advil)

yes no dk/u Penicillin or other antibiotics

yes no dk/u Sulfa drugs

yes no dk/u Codeine or other narcotics

yes no dk/u Metals (jewelry, clothing snaps)

yes no dk/u Latex (gloves, balloons)

yes no dk/u Vinyl

yes no dk/u Acrylic

yes no dk/u Animals

yes no dk/u Foods (specify) _____

yes no dk/u Other substances (specify) _____

yes no dk/u Are you taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.

Medication: _____

Taken For: _____

Medication: _____

Taken For: _____

Medication: _____

Taken For: _____

yes no dk/u Do you currently have or ever had a substance abuse problem?

yes no dk/u Do you smoke or chew tobacco?

yes no dk/u Operations? Describe: _____

yes no dk/u Hospitalized? For: _____

yes no dk/u Other physical problems or symptoms?

Describe: _____

yes no dk/u Being treated by another health care professional?

For: _____

Date of most recent physical exam?: _____

Do you have any other medical conditions we should know about?

_____

Women Only

yes no dk/u Are you pregnant?

yes no dk/u Are you anticipating becoming pregnant?

DENTAL HISTORY Now or in the past, has the patient had:

yes no dk/u Permanent or "extra" (supernumerary) teeth removed?

yes no dk/u Supernumerary (extra) or congenitally missing teeth?

yes no dk/u Chipped or otherwise injured primary (baby) or permanent teeth?

yes no dk/u Teeth sensitive to hot or cold; teeth throb or ache?

yes no dk/u Jaw fractures, cysts, mouth infections?

yes no dk/u "Dead Teeth", root canals treated?

yes no dk/u Bleeding gums, bad taste, mouth odor?

yes no dk/u Periodontal "Gum Problems"?

yes no dk/u Food impaction between teeth?

yes no dk/u "Gum Boils", frequent canker sores, cold sores?

yes no dk/u Thumb, finger, sucking habit? Until what age? _____

yes no dk/u Abnormal swallowing habit (tongue thrusting)?

yes no dk/u History of speech problems?

yes no dk/u Mouth breathing habit, snoring, difficulty in breathing?

yes no dk/u Tooth grinding, jaw clenching?

yes no dk/u Any pain, clicking or locking in jaw or ringing in the ears?

yes no dk/u Any pain or soreness in the muscles of the face, or around the ears?

yes no dk/u Difficulty in chewing or jaw opening?

yes no dk/u Have you ever been treated for "TMD" or "TMJ" problems?

yes no dk/u Aware of loose, broken, or missing restorations (fillings)?

yes no dk/u Any teeth irritating cheek, lip, tongue or palate?

yes no dk/u Concerned about spaced, crooked or protruding teeth?

yes no dk/u Aware or concerned about under or over developed jaw?

yes no dk/u Any relative with similar tooth or jaw relationships?

yes no dk/u Any wisdom tooth problems?

yes no dk/u Had periodontal (gum) treatment?

yes no dk/u Have you ever had any serious trouble associated with any previous dental treatment?

yes no dk/u Been under another dentist's care?

Specialist: _____ Other: _____

yes no dk/u Ever had a prior orthodontic examination or treatment?

yes no dk/u Would you object to wearing orthodontic appliances (braces) should they be indicated?

How often do you brush: _____ Floss: _____

What is your primary concern? Why are you here? _____

I have read and understand the above questions. 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. If there are any changes later to this history record or medical / dental status, I will so inform this practice.

_____

Signature Date

I hereby authorize SmartSmiles Orthodontics, or OrthoBanc, LLC on behalf of SmartSmiles Orthodontics, to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options.

_____

Signature Date