Adult Patient Health Record

A

Name ______________________ Date of Birth ______________ Age ______________

☐ Male ☐ Female Email ______________________

Home Phone ( ) ______________ Work Phone ( ) ______________ Ext. ______ Cell / Other ( ) ______________

Home Address ______________________
Street Apt # City State / Zip

Employer ______________________ Occupation ______________________

Address ______________________
Street Suite # City State / Zip

If you have Orthodontic Insurance Coverage, please fill out below:

Drivers License # Social Security # ID#

Insurance Co. Name Group # (Plan, Local or Policy) Phone

Street Address City State / Zip

Spouse

Name ______________________ Date of Birth ______________ Age ______________

☐ Male ☐ Female Email ______________________

Home Phone ( ) ______________ Work Phone ( ) ______________ Ext. ______ Cell / Other ( ) ______________

Home Address ______________________
Street Apt # City State / Zip

Employer ______________________ Occupation ______________________

Address ______________________
Street Suite # City State / Zip

If your spouse has Orthodontic Insurance Coverage, please fill out below:

Drivers License # Social Security # ID#

Insurance Co. Name Group # (Plan, Local or Policy) Phone

Street Address City State / Zip

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize the release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature Date

What is Your Primary Concern? ______________________

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

Yes	No	dk/u	
☐	☐	☐	Permanent or "Extra" (Supernumerary) Teeth Removed?
☐	☐	☐	Chipped or Injured Primary (Baby) / Permanent Teeth?
☐	☐	☐	Bleeding Gums, Bad Taste or Mouth Odor?
☐	☐	☐	Periodontal "Gum" Problems/Treatment?
☐	☐	☐	Mouth Breathing Habit, Snoring or Difficulty in Breathing?
☐	☐	☐	Tooth Grinding, Jaw Clenching, Clicking or Locking?

Yes	No	dk/u	
☐	☐	☐	Any Pain in Jaw or Ringing in the Ears?
☐	☐	☐	Any Pain or Soreness in the Muscles of the Face or Around the Ears?
☐	☐	☐	Difficulty Encountered in Chewing or Jaw Opening?
☐	☐	☐	Aware or Concerned about Under or Over-Developed Jaw?
☐	☐	☐	Any Relative with Similar Tooth or Jaw Relationships?
☐	☐	☐	Ever Had a Prior Orthodontic Examination or Treatment?

I understand that the information I have given is correct to the best of my knowledge, that it 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 the necessary dental/orthodontic services I may need.

Signature Date

Medical History

A

Now or in the past, have you had:

Yes	No	dk/u	
☐	☐	☐	Abnormal Blood Pressure (High or Low)
☐	☐	☐	AIDS, ARC, HIV Positive or Other STD
☐	☐	☐	Allergies or Hives - Hay Fever, Asthma, Sinus Trouble
☐	☐	☐	Anemia, Excessive Bleeding or Bruising Tendency
☐	☐	☐	Anorexia or Bulimia
☐	☐	☐	Arthritis or Rheumatoid Conditions
☐	☐	☐	Artificial Heart Valve(s)/Bones/Joints
☐	☐	☐	Asthma
☐	☐	☐	Birth Defects or Hereditary Problems
☐	☐	☐	Bleeding Disorders or Taking Blood Thinners
☐	☐	☐	Blood Transfusions
☐	☐	☐	Bone Fractures or Any Major Accidents
☐	☐	☐	Cancer or Tumor/Chemo/Radiation Treatments
☐	☐	☐	Cankers or Cold Sores (Mouth or Body)
☐	☐	☐	Chest Pain, Shortness of Breath or Swelling Ankles
☐	☐	☐	Congenital Heart Defect(s)
☐	☐	☐	Diabetes
☐	☐	☐	Epilepsy, Seizures or Convulsions
☐	☐	☐	Eye, Ear, Nose or Throat Condition
☐	☐	☐	Fainting or Dizzy Spells
☐	☐	☐	Frequent Headaches, Colds or Sore Throat
☐	☐	☐	Glaucoma
☐	☐	☐	Handicapped or Disabled
☐	☐	☐	Heart Disease or Attack
☐	☐	☐	Heart Murmur (e.g. Mitral Valve Prolapse)
☐	☐	☐	Hepatitis (A, B or C)
☐	☐	☐	Herpes
☐	☐	☐	High or Low Blood Pressure
☐	☐	☐	Implant (Joint, Eye, Breast, or Other)
☐	☐	☐	Immune System Conditions
☐	☐	☐	Jaundice or Other Liver Disorder
☐	☐	☐	Kidney Disease
☐	☐	☐	Mental Health, Behavioral Problems or Depression
☐	☐	☐	Organ Transplant
☐	☐	☐	Rheumatic Fever
☐	☐	☐	Sickle Cell Anemia
☐	☐	☐	Stomach Ulcer or Hyperacidity
☐	☐	☐	Thyroid Disease or Endocrine Problems
☐	☐	☐	Tonsil or Adenoid Conditions
☐	☐	☐	Tuberculosis (TB)
☐	☐	☐	Ulcers (Stomach, Intestine, Mouth)
☐	☐	☐	Vision, Hearing, Tasting or Speech Difficulties
☐	☐	☐	Weight Loss (Recent) or Poor Appetite

Are There Any Other Medical Conditions That We Should Be Aware Of?

____

____

Allergies or Reactions to any of the following:

Yes	No	dk/u	
☐	☐	☐	Local Anesthetics (Novocaine or Lidocaine)
☐	☐	☐	Aspirin
☐	☐	☐	Ibuprofen (Motrin, Advil)
☐	☐	☐	Penicillin or Other Antibiotics
☐	☐	☐	Sulfa Drugs
☐	☐	☐	Codeine or Other Narcotics
☐	☐	☐	Metals (Jewelry, Clothing Snaps)
☐	☐	☐	Acrylic
☐	☐	☐	Latex (Gloves, Balloons)
☐	☐	☐	Vinyl
☐	☐	☐	Are You Taking Medications, Nutritional Supplements, Herbal Medications or Non-Prescription Medicines? Please List Below:

Medication: ______________ Taken for: ______________

Medication: ______________ Taken for: ______________

Medication: ______________ Taken for: ______________

Medication: ______________ Taken for: ______________

Yes	No	dk/u	
☐	☐	☐	Do You Have or Ever Had a Substance Abuse Problem?
☐	☐	☐	Do You Chew or Smoke Tobacco?
☐	☐	☐	Operations? Describe: ______________
☐	☐	☐	Hospitalized? For: ______________
☐	☐	☐	Other Physical Problems or Symptoms? Describe: ______________
☐	☐	☐	Being Treated by Another Health Care Professional? For: ______________
			Date of Most Recent Physical Exam: ______________
☐	☐	☐	Have You Ever Taken Bisphosphonates or Any Other Drug For Osteoporosis/Osteopenia? Describe: ______________

Females only:

Yes	No	dk/u	
☐	☐	☐	Are You Taking Birth Control?
☐	☐	☐	Are You Taking Hormones?
☐	☐	☐	Are You Pregnant?
☐	☐	☐	Are You Nursing?

Family Medical History

Do Your Parents or Siblings Have Any of the Following Health Problems? If so, Please Explain:

Yes	No	dk/u	
☐	☐	☐	Bleeding Disorders
☐	☐	☐	Diabetes
☐	☐	☐	Arthritis
☐	☐	☐	Metabolic Disturbances
☐	☐	☐	Severe Allergies
☐	☐	☐	Unusual Dental Problems
☐	☐	☐	Jaw Size Imbalance
☐	☐	☐	Any Other Medical Conditions That We Should Know About? ______________

What other disease, condition, or problem do you have that is not previously listed? ______________

I certify that the above information is correct to the best of my knowledge. I understand I must notify Dr. Liz Gesenhues and/or her staff immediately at any time my information changes.

Signature ______________ Date ______________

I authorize the release of medical/dental information to any of the following if needed: My physician, any other physician or other dental offices I may be referred to, attorneys (with my prior release by signature), and my insurance company.

Signature ______________ Date ______________

I understand Dr. Liz Gesenhues may photograph my face and mouth for the purpose of documentation in my record. _______ (Initial)

I further understand and grant my permission to Dr. Liz Gesenhues to use my photographs for educating other patients, prospective patients or other health care professionals, which may include but not be limited to, inclusion on Dr. Gesenhues' website, office photographs or video.

Signature ______________ Date ______________