Skopek Orthodontics
Medical/Dental History - Adult

Date: _____ Referred by: _____

Patient's Name: Sex: Age: Birthdate:

Prefers to be addressed as: Home Phone: Cell Phone:

Address: City: State: Zip: Email Address:

Employed by: Occupation: Work Phone:

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

Spouse's Name: Occupation: Work Phone:

If Children, Name: Name:

Employed by: DOB: DOB:

Person Responsible for Account:
❑ Self ❑ Spouse ❑ Other: SS#: Home Phone:

Address: Business Phone: Cell Phone:

DENTAL INSURANCE

Primary Insurance Co: Gr. #: Ortho Coverage ❑ Yes ❑ No

Insured's Name: SS#: Birthdate:

Secondary Insurance Co: Gr. #: Ortho Coverage ❑ Yes ❑ No

Insured's Name: SS#: Birthdate:

Other Insurance Information:

DENTAL HISTORY

1. Patient's Dentist: Date of Last Visit:
2. Have there been any injuries to the face, mouth or teeth? ❑ YES ❑ NO
3. Have you had or do you presently have any of the following habits? ❑ NO ❑ Thumb or finger sucking ❑ Lip Biting ❑ Snoring ❑ Grinding of teeth at night ❑ Mouth Breathing
4. Have you been informed of any missing or extra permanent teeth? ❑ YES ❑ NO
5. Are you aware of sores, lumps or irritated areas of the mouth? ❑ YES ❑ NO
6. Has an orthodontist been consulted previously? ❑ YES ❑ NO
   Name: Date:
7. Have you ever been treated for: ❑ Bad Bite ❑ TMJ ❑ Periodontal Disease ❑ None
   If so, by whom?:
8. Do you have any speech problems? ❑ YES ❑ NO
9. Are you frightened or anxious about Orthodontic treatment? ❑ YES ❑ NO
10. Are you concerned about the appearance of your teeth? ❑ YES ❑ NO
11. Is there anything you would like to change about your smile? ❑ YES ❑ NO
    If so, what:
12. What aspect of dental treatment are you most concerned with? ❑ Quality ❑ Cost ❑ Discomfort ❑ Time
13. Reason for consultation (chief concern):
14. Has any other family member had orthodontic treatment? ❑ YES ❑ NO
    Were they satisfied with the results? ❑ YES ❑ NO Stage of TX: _____
    Children (Dr._____) Spouse (Dr_____) Other Family Members (Dr._____)

MEDICAL HISTORY

1. Is your general health good at this time? ❑ YES ❑ NO
2. Are you under the care of a physician at this time? ❑ YES ❑ NO If yes, explain:
3. What is the name of your family physician? Date of last physical:
4. Are you taking any medication? ❑ YES ❑ NO (List medications under notes)
5. Are you allergic to any medication? (Penicillin, Sulfa, etc.) ❑ YES ❑ NO
   Name:
6. Have you ever had a serious illness or been hospitalized? ❑ YES ❑ NO
   Explain:
7. Have you had your tonsils and/or adenoids removed? ❑ YES ❑ NO
   Age:
8. Do you have any special problems not listed? ❑ YES ❑ NO
   Explain:
9. Have you ever been advised by your physician to take an antibiotic prior to any dental treatments? ❑ YES ❑ NO
   If yes, antibiotic name and method: Reason:
10. Do you use tobacco? (smoking or chewing) ❑ YES ❑ NO
11. What is your approximate height? Weight?
12. WOMEN:
    Are you pregnant or considering pregnancy during the next 2 years? ❑ YES ❑ NO Are you nursing? ❑ YES ❑ NO
    Are you currently taking medication for birth control? ❑ YES ❑ NO

DO YOU HAVE NOW, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO		YES	NO
TUBERCULOSIS	❑	❑	RESPIRATORY LUNG DISEASE	❑	❑	ADD/ADHD	❑	❑
ENDOCARDITIS	❑	❑	HIGH BLOOD PRESSURE	❑	❑	KIDNEY TROUBLE	❑	❑
HEART CONDITION	❑	❑	LOW BLOOD PRESSURE	❑	❑	LIVER DISEASE	❑	❑
HEART PACEMAKER	❑	❑	HEPATITIS (type?_____)	❑	❑	PSYCHIATRIC TREATMENT	❑	❑
HEART ANGINA	❑	❑	VENEREAL DISEASE	❑	❑	DRUG ADDITION	❑	❑
HEART ATTACK	❑	❑	HERPES (ORAL-COLD SORES)	❑	❑	HEADACHES	❑	❑
MITRAL VALVE PROLAPSE	❑	❑	BLOOD DISORDERS/BLEEDING PROBLEMS	❑	❑	EARACHES	❑	❑
CONGENITAL HEART DISEASE	❑	❑	INFLAMMATORY RHEUMATISM	❑	❑	JAW CLICKING	❑	❑
ARTIFICIAL HEART VALVE	❑	❑	ARTHRITIS	❑	❑	ALLERGIES	❑	❑
HEART SURGERY;date ____	❑	❑	ULCERS	❑	❑	ALLERGIES TO METAL	❑	❑
HEART MURMUR	❑	❑	STROKE	❑	❑	JAW PAIN	❑	❑
RHEUMATIC FEVER	❑	❑	ANEMIA	❑	❑	TONSILLITIS	❑	❑
PROSTHETIC (ARTIFICIAL) JOINT	❑	❑	ASTHMA	❑	❑	EMOTIONAL PROBLEMS	❑	❑
X-RAY/RADIATION (CANCER) THERAPY	❑	❑	EPILEPSY	❑	❑	BLOOD TRANSFUSION	❑	❑
AIDS OR H.I.V. POSITIVE	❑	❑	GLAUCOMA	❑	❑	OTHER: _____	❑	❑
DIABETES	❑	❑	FAINTING SPELLS	❑	❑		❑	❑

MEMO:

I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct. THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE INFORMATION. I grant authority to the Doctor and Staff to perform all procedures and treatments in my best interest. I authorize the Orthodontist to share treatment information with collaborating dentists and surgeons when appropriate. I authorize the Orthodontist to submit treatment information pertinent to this patient to the Insurance Company for billing purposes only. I understand that, when appropriate, Credit Bureau reports may be obtained.

Signature of Patient

_____

Signature of Orthodontist

_____

Today's Date _____

Update _____ Initial_____

Update _____ Initial_____

Update _____ Initial_____

Update _____ Initial_____

NOTES:

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