KUJAK ORTHODONTICS

Health History Form

For Adult Patients

Patient

First Name _____ Last Name _____MI _____Birthdate ___ /____/____Gender_____

I prefer to be called_____ Hobbies/Interests _____

Marital Status ☐ Single ☐ Married ☐ Seperated ☐ Divorced ☐ Widowed

Home Address _____ City, State, Zip Code _____

Cell Phone _____Home Phone _____Work Phone _____

E-mail Address _____ Social Security # _____

Employer _____Occupation _____

Whom may we thank for referring you? ☐Dentist ☐Friend (*name*)_____☐Other_____

Dental Office _____Dentist _____Last dental visit date_____

Medical facility where you receive care_____

☐ **I am aware that I will need to miss work/school in order to attend some orthodontic appoinments.**

Closest Relative

Spouse/closest relative's name _____ Relationship to patient _____

Address (*if different than patient address*)_____Cell Phone _____

Financial Responsibility

Who is financially responsible for this account?_____Social Security #_____

Address (*if different than patient address*)_____ Cell Phone _____

E-mail Address_____ Employer _____

Who will be responsible for bringing the patient to orthodontic appointments?

_____

Dental Insurance

Primary

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Unsure

Policy holder's full name _____ Birthdate ___ /___ /____ Social Security # _____

Insurance Co. Name _____ Insurance Co. Address _____

Employer _____ Group # _____ ID # _____

Secondary

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Unsure

Policy holder's full name _____ Birthdate___ /___ /____ Social Security # _____

Insurance Co. Name _____ Insurance Co. Address _____

Employer _____ Group # _____ ID # _____

Continue to back side

Medical History

Now or in the past have you ever had:

- Y N Intravenous medication for bone disorders or cancer such as bisphosphonates like Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate)?
- Y N Oral medication for bone disorders such as bisphosphonates like Fosamax (aledndronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate)?
- Y N Birth defects or hereditary problems?
- Y N Bone fractures or major injuries?
- Y N Any injuries to the face, head, neck?
- Y N Arthritis or joint problems?
- Y N Endocrine or thyroid problems?
- Y N Diabetes or low sugar?
- Y N Kidney problems?
- Y N Cancer, tumor, radiation treatment orchemotherapy?
- Y N Stomach ulcer, hyperacidity, acid reflux?
- Y N Immune system problems?
- Y N History of osteoporosis?
- Y N Gonorrhea, syphilis, herpes, sexually transmitted diseases?
- Y N AIDS or HIV positive?
- Y N Hepatitis, jaundice or other liver problem?
- Y N Polio, mononucleosis, tuberculosis, pneumonia?
- Y N Seizures, fainting spells, neurologic problem?
- Y N Mental health disturbance or depression?
- Y N Vision, hearing or speech problems?
- Y N History of eating disorder (anorexia, bulimia)?
- Y N High or low blood pressure?
- Y N Excessive bleeding or bruising, anemia?
- Y N Chest pain, shortness of breath, tire easily, swollen ankles?
- Y N Heart defects, heart murmur, rheumatic heart disease?
- Y N Angina, arteriosclerosis, stroke or heart attack?
- Y N Skin disorder (other than common acne)?
- Y N A consistent, well balanced diet?
- Y N Frequent headaches or migraines?
- Y N Frequent ear infections, colds, throat infections?
- Y N Asthma, sinus problems, hayfever?
- Y N Tonsil or adenoid condition?
- Y N Frequent ear infections, colds, throat infections?
- Y N A habit of chewing tobacco, smoking, or vaping?
- Y N Noticeable changes in your face or jaws?
- Y N To take antibiotic pre-medication before dental procedures?

Have you ever had allergies or reactions to the following:

- Y N Latex (gloves, balloons)
- Y N Metals (jewelry, clothing snaps)
- Y N Acrylics
- Y N Aspirin
- Y N Ibuprofen (Motrin, Advil)

Other substances_____

Medications

Please list any medications that you take:

_____

Dental History

Now or in the past have you ever had:

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

Females

- Y N Are you pregnant? ☐ Unsure
- Y N Are you trying to become pregnant?

Signature Needed

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. The office reserves the right to verify the credit status of potential patients and/or parents of patients 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.

Signature Date