Member American Association of Orthodontists
My Life. My Smile. My Orthodontist.®

HOLMAN ORTHODONTICS
Bracing for the Future.

Date: _____

CONFIDENTIAL MEDICAL/DENTAL HISTORY FORM – ADULT

PATIENT INFORMATION

Patient's Name: _____ I Prefer To Be Called: _____ DOB: __/__/__ Age: _____ Sex: M/F

Patient's Address: _____ City: _____ State: _____ Zip Code: _____

S.S.N.: _____ E-mail address: _____

Home Phone No.: _____ Cell Phone: _____ Carrier: _____ Work Phone No.: _____

Please circle how you like to receive appointment reminders. You may choose multiple: **Email** **Text Message** **Phone Call**

Patient Marital Status: _____ Spouse's Name: _____

Sports, Hobbies, And/Or Interests: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone No.: _____ Relationship to You: _____

Who suggested that you might need orthodontic treatment? _____

How did you first learn about our office? _____

Name Of Dentist: _____ Date Last Seen: _____ Reason: _____

Name Of Physician(s): _____ Date Last Seen: _____ Reason: _____

DENTAL INSURANCE INFORMATION

Primary Policy Holder's Name: _____ SS#: _____ ID#: _____ DOB: __/__/__

Insurance Company: _____ Phone #: _____

Insurance Company Address: _____

Secondary Policy Holder's Name: _____ SS#: _____ ID#: _____ DOB: __/__/__

Insurance Company: _____ Phone #: _____

Insurance Company Address: _____

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

- ☐yes ☐no Any teeth removed for any reason?
- ☐yes ☐no Supernumerary (extra) or congenitally missing teeth?
- ☐yes ☐no Chipped or otherwise injured primary (baby) or permanent teeth?
- ☐yes ☐no Teeth sensitive to hot or cold; teeth throb or ache?
- ☐yes ☐no Jaw fractures, cysts or mouth infections?
- ☐yes ☐no "Dead teeth" or root canals treated?
- ☐yes ☐no Periodontal problems. Bleeding gums, bad taste or mouth odor?
- ☐yes ☐no Thumb, finger, or sucking habit? Until what age _____?
- ☐yes ☐no Abnormal swallowing habit (tongue thrusting)?
- ☐yes ☐no History of speech problems?
- ☐yes ☐no Mouth breathing habit, snoring or difficulty in breathing?
- ☐yes ☐no Tooth grinding, jaw clenching clicking or locking?
- ☐yes ☐no Any pain in jaw or ringing in the ears?
- ☐yes ☐no Difficulty encountered in chewing or jaw opening?
- ☐yes ☐no Have you ever been treated for "TMD" or "TMJ" problems?
- ☐yes ☐no Aware of loose, broken or missing restorations (fillings)?
- ☐yes ☐no Any teeth irritating cheek, lip, tongue or palate?
- ☐yes ☐no Frequent canker sores or cold sores?
- ☐yes ☐no Any wisdom teeth problems?
- ☐yes ☐no Is patient sensitive or self-conscious about teeth?
- ☐yes ☐no Ever had a prior orthodontic examination or treatment?

How often do you brush? _____ Floss? _____

How do you feel about braces? _____

What concerns you most about your teeth? _____

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

- ☐yes ☐no Birth defects or hereditary problems?
- ☐yes ☐no Bone fractures, any major accidents?
- ☐yes ☐no Rheumatoid or arthritic conditions?
- ☐yes ☐no Endocrine or thyroid problems?
- ☐yes ☐no Kidney problems?
- ☐yes ☐no Diabetes?
- ☐yes ☐no Cancer, tumor, radiation treatment or chemotherapy?
- ☐yes ☐no Stomach ulcer or hyperacidity?
- ☐yes ☐no Polio, mononucleosis, tuberculosis or pneumonia?
- ☐yes ☐no Problems of the immune system? AIDS or HIV positive?
- ☐yes ☐no Hepatitis, jaundice or liver problem?
- ☐yes ☐no Fainting spells, seizures, epilepsy or neurological problem?
- ☐yes ☐no Mental health disturbance or behavioral problem?
- ☐yes ☐no Vision, hearing, lisping or speech difficulties?
- ☐yes ☐no Loss of weight recently, poor appetite?
- ☐yes ☐no History of eating disorder (anorexia, bulimia)?
- ☐yes ☐no Excessive bleeding or bruising tendency, anemia or bleeding disorder?
- ☐yes ☐no High or low blood pressure?
- ☐yes ☐no Chest pain, shortness of breath or swelling ankles?
- ☐yes ☐no Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, atherosclerosis, stroke, congenital heart defects, heart murmur or rheumatic heart disease)?
- ☐yes ☐no Skin disorder?
- ☐yes ☐no Does the patient eat a well-balanced diet?
- ☐yes ☐no Frequent headaches, colds or sore throats?
- ☐yes ☐no Eye, ear, nose or throat condition?
- ☐yes ☐no Hay fever, asthma, sinus trouble or hives?
- ☐yes ☐no Tonsil or adenoid conditions?

Circle allergies or reactions to any of the following:

Local anesthetics (Novocaine)?	Codeine or other narcotics
Aspirin	Ibuprofen (Motrin, Advil)
Penicillin or other antibiotics	Sulfa drugs
Metals (jewelry)	Latex (gloves, balloons)
Vinyl, Acrylic, or Animals	Foods (specify)

Please list any medication, nutrient supplements, herbal medications or non prescription medicine being taken by the patient

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

- ☐yes ☐no Current or past substance abuse problem?
- ☐yes ☐no Do you chew or smoke tobacco?
- ☐yes ☐no Operations or Surgery? Describe
- ☐yes ☐no Hospitalized? For _____
- ☐yes ☐no Being treated by another health care professional? For _____

Are there any other medical conditions that we should be aware of?

_____

WOMEN ONLY

- ☐yes ☐no Are you pregnant?
- ☐yes ☐no Do you anticipate becoming pregnant?

FAMILY MEDICAL HISTORY

List any family medical conditions that we should know about?

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. Further more, I consent to an orthodontic examination and, if necessary, orthodontic records which include photos, impressions for study models, and two radiographs.

Signed: _____ Date Signed: _____
(Patient)

Signed: _____ Date Signed: _____
(Dental Staff Member)

Holman Orthodontics

Dr. Brian Holman D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please Print Name of Responsible Party

Signature

Date

For Office Use Only

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)