PLEASE COMPLETE, PRINT AND BRING THIS FORM WITH YOU ON YOUR FIRST VISIT

Santa Monica Orthodontics
Love Your Smile!

## ADULT HEALTH HISTORY FORM PAGE 1 of 3

Date _____

Patient name _____
Last First Middle

Address _____
Street City Zip

Home phone _____ Work phone _____ Cell phone _____

Age _____ Birthdate _____ Social Security # _____

Email Address _____

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

Employer _____ Occupation _____ Years employed _____

Spouse's Name _____

Spouse's Employer _____ Occupation _____ Years employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Whom may we thank for referring you to our office? _____

**DENTAL INSURANCE INFORMATION**

Insured's Name _____ Insured's Social Security #

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

Do you have dual coverage? Yes_____ No _____ If yes: _____

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

**EMERGENCY INFORMATION**

Name of nearest relative not living with you

Complete address _____
Street City Zip

Phone _____

I understand that, where appropriate, credit bureau reports may be obtained.

Signature _____

Updates (date & initial) _____

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## ADULT HEALTH HISTORY FORM PAGE 2 of 3

**MEDICAL HISTORY**

Physician _____ Date of Last Visit _____
Address _____ Phone _____

Please circle Yes or No

Yes No Are you in good health? If No, please explain _____
Yes No Are you under the care of a Physician. If Yes, please explain? _____
Yes No Are you taking any medication? Birth Control? If Yes, please list? _____
Yes No Are you allergic to any medication? If Yes, please list _____
Yes No Are allergic to Latex? _____
Yes No Do you have a history of a major illness? If Yes, please list _____
Yes No Have you had any operations? If Yes, please list _____
Yes No Have you ever been involved in a serious accident? _____
Yes No Have you ever taken any weight loss medications, i.e PhenFen? _____
Yes No Do you drink alcohol? If Yes, please indicate frequency _____
Yes No Have you ever had a skin reaction to metal or jewelry? If Yes, please explain _____
Yes No Do you have a cardiac pacemaker, artificial heart valve, heart murmur or need to pre-medicate? _____
_____
Yes No Is there any family history of diabetes, heart murmur, or need to pre-medicate? _____
Yes No Have you ever smoked or chewed tobacco? _____
Yes No Have seen a physician in the last 12 months? Why? _____

Female Patients only:

Yes No Are you pregnant? If Yes, how many months? _____
Yes No Has menstruation started? If Yes, when _____

Circle any of the medical conditions below that you have had or currently have:

| | | | |
|---|---|---|---|
| Abnormal bleeding/Hemophilia☐ | Diabetes☐ | Hepatitis/Liver problems☐ | Pneumonia☐ |
| Anemia☐ | Dizziness☐ | Herpes☐ | Prolonged Bleeding☐ |
| Arthritis☐ | Epilepsy☐ | High Blood Pressure☐ | Radiation/Chemotherapy☐ |
| Asthma or Hay fever☐ | Gastrointestinal Disorders☐ | HIV / Aids☐ | Rheumatic Fever☐ |
| Bone Disorders☐ | Heart Problems☐ | Kidney problems☐ | Tuberculosis☐ |
| Congenital Heart Defect☐ | Heart Murmur☐ | Nervous Disorders☐ | Tumor or Cancer☐ |

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

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# ADULT HEALTH HISTORY FORM PAGE 3 of 3

**DENTAL HISTORY**

General Dentist _____ Date of last visit _____
What concerns are your primary dental concerns? _____

Please Circle Yes or No:

Yes No Are you presently in any dental pain? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry including anesthetic? _____
Yes No Have you ever had injuries to your face, mouth or teeth? _____
Yes No Have your wisdom teeth been removed? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where? _____
Yes No Do your gums bleed when you brush? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Are you a mouth breather? _____
Yes No Have you ever seen an orthodontist? If yes, who and when? _____
Yes No What is your attitude toward receiving orthodontic treatment? _____
Yes No Would you object to wearing orthodontic appliances (braces) should they be indicated? _____
Yes No Would you object to wearing orthodontic appliances (head gear) should they be indicated? _____
Yes No Has anyone in your family received orthodontic treatment? _____
How did they feel about the result? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
Yes No Are you aware of your jaw clicking or popping? _____
Yes No Are you aware of clenching your teeth during the day? _____
Yes No Have you ever been told that you grind your teeth? _____
Yes No Do you have “tension” headaches? _____
Yes No Have you ever experienced chronic ringing in your ears? _____
Yes No Are you aware that some appointments will be during work hours? _____

Female Patients only:

Yes No Are you pregnant? If Yes, how many months? _____
Yes No Has menstruation started? If Yes, when _____

**BENEFITS OF ORTHODONTICS**

Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Rehana Khan/Santa Monica Orthodontics to perform a complete orthodontic evaluation.

Signature: _____ Date: _____

Medical History Update: Have there been any changes in your health since your last appointment? If Yes, please explain:

_____

Are there any medical conditions that we have not discussed, which you feel we should be aware of? : If Yes, please explain:

_____

Signature: _____ Date: _____