CONFIDENTIAL

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MEDICAL DENTAL HISTORY – ADULT

Date _____

Patient's Last Name _____ First _____ Middle _____

Birthdate _____ Age _____ Sex _____ Home Phone No. _____

Name of Patient's Dentist _____ Name of Physician(s) _____

For the following questions circle **yes, no, or don't know/understand (dk/u)**. The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

MEDICAL HISTORY

yes no dk/u Birth defects or hereditary problems?
yes no dk/u Bone fractures, any major accidents?
yes no dk/u Rheumatoid or arthritic conditions?
yes no dk/u Endocrine or thyroid problems?
yes no dk/u Kidney problems?
yes no dk/u Diabetes?
yes no dk/u Cancer or been treated for a tumor?
yes no dk/u Stomach ulcer or hyperacidity?
yes no dk/u Polio, mono, tuberculosis, pneumonia?
yes no dk/u Problems of the immune system?
yes no dk/u Chest pain, shortness of breath or swelling ankles?
yes no dk/u Cardiovascular problems (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, *stroke, inborn heart defects or rheumatic heart*?
yes no dk/u Skin disorder?
yes no dk/u Do you have a normal and good diet?
yes no dk/u Frequent headaches, colds or sore throats?
yes no dk/u Any history of speech problems?
yes no dk/u Eye, ear, nose, throat condition?
yes no dk/u Hayfever, asthma, sinus trouble, hives?
yes no dk/u Tonsil or adenoid conditions?
yes no dk/u Allergies or drug reactions?
yes no dk/u Are you taking medication, nutrient supplements or non prescription medicine? Please name them.

_____

yes no dk/u Hepatitis, jaundice or liver problem?
yes no dk/u AIDS or HIV positive?
yes no dk/u Sexually transmitted disease?
yes no dk/u Fainting spells, seizures, epilepsy or neurologic disease?
yes no dk/u Mental health or behavorial problems?
yes no dk/u Vision, hearing, tasting or speech difficulties?
yes no dk/u Loss of weight recently, poor appetite?
yes no dk/u Excessive bleeding, black and blue tendency, anemia or bleeding disorder?
yes no dk/u High or low blood pressure?
yes no dk/u Easily tired?
yes no dk/u Do you currently have or ever had a substance abuse problem?
yes no dk/u Operations?
yes no dk/u Hospitalized? For _____
yes no dk/u Other physical problems or symptoms?
yes no dk/u Being treated by another health care professional?
For _____
yes no dk/u Are you in good health? Date of most recent physical exam? _____

Female Patient

yes no dk/u Are you pregnant?
yes no dk/u Are you taking birth control pills?
yes no dk/u Are you anticipating becoming pregnant?

DENTAL HISTORY

yes no dk/u Chipped or otherwise injured permanent teeth?
yes no dk/u Teeth sensitive to hot or cold; teeth throb or ache?
yes no dk/u Jaw fractures, cysts, mouth infections?
yes no dk/u "Dead teeth," root canals treated?
yes no dk/u Bleeding gums, bad taste, mouth odor?
yes no dk/u Periodontal "Gum Problems"?
yes no dk/u Food impaction between teeth?
yes no dk/u "Gum Boils," frequent canker sores, cold sores?

yes no dk/u Abnormal swallowing habit (tongue thrusting)?
yes no dk/u Mouth breathing habit, snoring, difficulty in breathing?
yes no dk/u Tooth grinding, jaw clenching, clicking, locking?
yes no dk/u Do you experience any pain or soreness in the muscles of your face, or around the ears?
yes no dk/u Any pain in jaw or ringing in the ears?
yes no dk/u Have you ever been treated for "TMJ" problems (Your jaw joint and facial muscle pain)?
yes no dk/u Difficulty encountered in chewing or jaw opening?

yes no dk/u Thumb, finger, sucking habit? Until _____

Continued on back

yes no dk/u History of supernumerary (extra) or congenitally missing teeth?

yes no dk/u Have any permanent teeth been removed?

yes no dk/u Aware of loose, broken or missing restorations (fillings)?

yes no dk/u Any teeth irritating cheek, lip, tongue, palate?

yes no dk/u Have you ever had Orthodontic treatment or worn a "retainer" or "bite plate"?

yes no dk/u Have you recently been under another dentist's care?

Specialist _____

yes no dk/u Have you ever had periodontal (gum) treatment?

yes no dk/u Concerned about spaced, crooked, protruding teeth?

yes no dk/u Aware or concerned about under or over developed jaw?

yes no dk/u Any relative with similar tooth or jaw relationships?

yes no dk/u Any wisdom tooth problems?

yes no dk/u Have you had any serious trouble associated with any previous dental treatment?

What is your primary concern? – Why are you here? _____

_____

_____

_____

Date of most recent dental examination _____

How often do you brush _____ floss _____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment?

_____

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.

_____

Signature Date

I authorize release of any information relating to this treatment claim. I understand that I am responsible for all costs of dental treatment. I hereby authorize insurance payment directly to the above-named dentist of the group insurance benefits otherwise payable to me.

Signed_____ Date _____

Medical History Update or Changes: Date: Comments: Signature:

Confidential RESPONSIBLE PARTY Information

Date_____

Responsible Party Last Name_____ Marital Status: Married Single Divorced

First Name_____ Middle Name_____

Address_____ City_____ State_____ Zip_____

How long at this address?_____ Home#_____ Cell#_____

Previous Address (if less that 3 years)

Address_____ City_____ State_____ Zip_____

Social Security #_____ Birthdate_____ Relation to Patient_____

Employer_____ Occupation_____ # Years Employed _____

Spouse's Last Name_____ Relation to Patient_____

First Name_____ Middle Name_____

Social Security #_____ Birthdate_____ Cell#_____

Employer_____ Occupation_____ # Years Employed _____

Confidential Patient Information

Patient's Last Name_____ First Name_____

Address_____ City_____ State_____ Zip_____

Patient's Cell#_____

Emergency Contact

Name of nearest relative not living with you _____

Complete Address_____

Phone#_____ Relation to Patient_____

I understand that where appropriate, a credit bureau "soft" report may be obtained.

Signature (Parent's signature if patient is a minor) X_____ Date _____

I authorize any release of information relating to this claim and authorize payment directly to Dr. Steven Brizendine. I understand that I am responsible for all costs of dental treatment.

X_____ Date _____

Steven F. Brizendine DDS, MS, Inc

* You May Refuse to Sign This Acknowledgment*

I have read this office's Notice of Privacy Practices. I may request a copy of this Notice at any time.

Print Name:_____

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)

Authorization for use of Photograph (s)

This office displays photographs of patients for the purpose of treatment and patient relations. Before a patient's photograph (s) is used, permission is obtained from the patient and the use of the photograph (s) is held to specific conditions.

Conditions

- The photograph (s) is to be displayed in a professional manner at this location only.
- Patient's personal information associated with the photograph (s) will be restricted.
- The photograph (s) will not to be displayed for marketing or commercial purposes outside of this office.
- If the photograph (s) is used for teaching treatment procedures, the photograph (s) will be altered to protect the identity of the patient.
- This authorization and the use of the patient's photograph (s) will terminate upon the completion of treatment.
- Patient has the right to revoke the use of their photograph (s) at anytime.

Authorization

By signing this authorization, you are permitting the use of your photograph (s) base upon the conditions of this authorization.

You understand that any changes in the conditions of this authorization and/or use of your photograph (s) will automatically terminate this authorization and the use of your photograph (s). You also understand that you may revoke this authorization and the use of your photograph (s) in writing at anytime.

I _____ (patient's name) have read this authorization and therefore give permission for the use of my photograph (s). By doing so, I release this office of any liability that may result from the use of my photograph (s)

_____

Patient's Signature Date

If the patient is a minor (under 18 years of age), a parent or legal guardian must sign.

_____

Parent or Guardian's Signature Date