Trieu Smiles ORTHODONTICS

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: _____
SSN: _____ Home Phone No.: _____ Cell Phone No.: _____ Work Phone#: _____
Email address: _____ 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 No: _____
Insurance Company Address: _____ City: _____ State: _____ Zip: _____
Secondary Policy Holder's Name: _____ SS#: _____ ID#: _____ DOB: ___/___/___
Insurance Company: _____ Phone No: _____
Insurance Company Address: _____ City: _____ State: _____ Zip: _____

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 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 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 tooth 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? _____
How often do you 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 systems? 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, tasting 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, arteriosclerosis, stroke, inborn 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 throat?
☐yes ☐no Eye, ear, nose or throat conditions?
☐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)	Foods (specify):_____
Vinyl, acrylic, or animals	No known drug allergies
Latex (gloves, balloons)	

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 Does the patient chew or smoke tobacco?
☐yes ☐no Operation or Surgery? Describe: _____
☐yes ☐no Hospitalized? For: _____
☐yes ☐no Being treated by another health care professional? For: _____
☐yes ☐no Are there any other medical conditions that we should be aware of? Specify: _____

_____

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?

_____
_____

RELEASE AND WAIVER

I hereby authorize release of any information related to insurance claims and authorize payment of any insurance benefits to Trieu Smiles LLC. Further more, I consent to treatment and authorize the dental staff to perform the necessary dental services I may need during treatment. I have read and understand the above questions. I will not hold my orthodontist or any members 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.

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