BURNS PARK
ORTHODONTICS, P.C.

1303 PACKARD STREET, SUITE 101
ANN ARBOR, MICHIGAN 48104-3874
(734) 761-3116

ADULT PERSONAL HEALTH RECORD

Patient's Name _____ Birthdate _____ Sex _____

Address _____ Pronoun(s) _____

Preferred Phone _____ E-mail _____Marital Status _____

Employed By _____ Work Phone _____

Dentist _____ Physician _____

Who may we thank for referring you? _____

Person responsible for the account _____

Name _____

Address _____ Home Phone _____

Employer _____ Work Phone _____

ORTHODONTIC INSURANCE

Primary Insurance Co. _____ Group# _____ Birthdate _____

Subscriber Name _____ ID#/SS# _____

Secondary Insurance Co. _____ Group# _____ Birthdate _____

Subscriber Name _____ ID#/SS# _____

MEDICAL HISTORY

1. Are you in good health? _____ Yes _____ No _____
2. Are you presently under a physician's care? _____ Yes _____ No _____
3. Have you ever been severely ill or hospitalized? _____ Yes _____ No _____
4. List any drugs or medicines currently being taken (dosage and reason) _____
5. List any drug sensitivities or allergies of which you are aware _____
6. Females: Are you pregnant? Yes_____ No___ Estimated date of delivery _____
7. Check any of the following conditions for which you have been treated

_____ Diabetes	_____ Anemia	_____ ADHD
_____ Pneumonia	_____ Prolonged Bleeding	_____ Autism
_____ Asthma	_____ Fainting/Dizziness	_____ Anxiety Disorder
_____ Tuberculosis	_____ Heart Condition	_____ Depression/OCD
_____ Kidney Disease	_____ High/Low Blood Pressure	_____ Eating Disorder
_____ Hepatitis/Liver Disease	_____ Heart Murmur	_____ Epilepsy
_____ STIs	_____ Rheumatic Fever	_____ Frequent Colds/Sore Throat
_____ HIV/AIDS	_____ Pacemaker/Heart Valve	_____ Tonsils/Adenoids Removed
_____ Congenital Abnormalities	_____ Osteoporosis/Bone Disorder	_____ Speech Therapy

Other: _____

DENTAL HISTORY

1. Have you had a recent dental exam or treatment? _____ Date _____ Yes _____ No _____
2. Have you had a previous orthodontic exam or treatment? _____ Yes _____ No _____
3. Have there ever been any injuries to the mouth, face, or teeth? _____ Yes _____ No _____
4. Have you ever had teeth extracted? _____ Yes _____ No _____
5. Have you ever been informed of missing or extra teeth? _____ Yes _____ No _____
6. Have you had, or presently have, any of the following habits? _____ Yes _____ No _____

   _____ Thumb or Finger Sucking _____ Lip Biting _____ Snoring

   _____ Grinding Teeth at Night _____ Mouth Breathing
7. Do you have frequent cold or canker sores? _____ Yes _____ No _____
8. Do you ever complain of swollen, tender, or bleeding gums? _____ Yes _____ No _____
9. Are you aware of a tired, tense feeling in the facial muscles or joints of the jaw? _____ Yes _____ No _____
10. Are you especially apprehensive toward dental visits? _____ Yes _____ No _____
11. a.) Do other family members have similar conditions? _____ Yes _____ No _____

    b.) Have any family members had orthodontic treatment? _____ Yes _____ No _____
12. Reason for this exam (chief concern) _____
13. List hobbies, sports, and musical instruments played _____

    _____

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize and request my insurance company to pay directly to the orthodontist the insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf. I give consent to Burns Park Orthodontics to use and disclose my protected health information to carry out treatment, payment activities, and healthcare operations.

X _____ _____

SIGNATURE DATE