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Orthodontics **Telephone 734/761-3116**

Adult Personal Health Record

Patient's Name _____ Birthdate _____ Gender _____
Address _____ City _____ Zip _____
Preferred Phone _____ Alternate Phone _____ 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#_____ Phone _____
Subscriber Name _____ ID#/SS# _____ Birthdate _____
Secondary Insurance Co. _____ Group# _____ Phone _____
Subscriber Name _____ ID#/SS# _____ Birthdate _____

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 now being taken. (Give dosage and reason) _____
5. List any drug sensitivities or allergies of which you are aware. _____
6. Women: 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
_____ STD	_____ 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 Drs. Clinthorne and Kim's office to use and disclose my protected health information to carry out treatment, payment activities, and healthcare operations.

X _____ _____

SIGNATURE **DATE**