ADULT HEALTH HISTORY

The better we communicate, the better we can care for you. To help us meet all of your orthodontic needs, please fill out this form completely.

SLOSS & CARPENTER ORTHODONTICS

About You

Name:_____

I prefer to be called:_____

Male ☐ Female ☐ Birth date:_____Age:_____

E-mail Address:_____

Home Address: _____

_____

Cell #:_____Home #:_____

Work #:_____Extension:_____

Best times to reach you?_____

Employer:_____

How long there?_____Occupation:_____

Single Married Divorced Widowed Separated

If married, Name of Spouse: _____

Referred by:_____

Other family members seen by us:_____

_____

General Dentist: _____

Last Visit Date: _____

Orthodontic Insurance

PRIMARY INSURANCE

Insurance Co. Name:_____

Insurance Co. Address:_____

City, State, Zip:_____

Insurance Co. Phone #: _____

Insured's Name:_____Relation:_____

Insured's Birthdate:_____Group #:_____

Insured's ID or SSN #:_____

SECONDARY INSURANCE

Insurance Co. Name:_____

Insurance Co. Address:_____

City, State, Zip:_____

Insurance Co. Phone #: _____

Insured's Name:_____Relation:_____

Insured's Birthdate:_____Group #:_____

Insured's ID or SSN #:_____

Billing Party

Name:_____

Male ☐ Female ☐ Birth date:_____Age:_____

Billing Address: _____

E-mail Address: _____

Driver's License #: _____ SSN: _____

Cell #:_____Home #:_____

Work #:_____Extension:_____

Employer:_____

How long there?_____Occupation:_____

Medical History

Do you have a personal physician? Y N Physician's Name: _____

Phone:_____Last visit date:_____

Are you currently under the care of a physician? Y N

Please explain:

Emergency Contact Name: _____

Relationship: _____

Cell #:_____Home #:_____

Work #:_____Extension:_____

Continued on next page

Medical History (continued)

Your current physical health is: GOOD FAIR POOR

Do you smoke or use tobacco in any form? Y N

If yes, how much per day? _____ How many years? _____

Are you taking any prescription, over-the-counter, or herbal supplemental drugs? Y N

If yes, please list: _____

FOR WOMEN: Are you using a prescribed method of birth control? Y N

Are you pregnant? Y N If yes, week #: _____

Are you nursing? Y N

Have you ever had any of the following diseases or medical problems?

	YES	NO		YES	NO
Abnormal Bleeding	☐	☐	HIV+/AIDS	☐	☐
ADHD	☐	☐	Kidney Problems	☐	☐
Alcohol/Drug Abuse	☐	☐	Liver Disease	☐	☐
Anemia	☐	☐	Low Blood Pressure	☐	☐
Arthritis	☐	☐	Lupus	☐	☐
Artificial Bone(s)	☐	☐	Mitral Valve Prolapse	☐	☐
Artificial Joint(s)	☐	☐	Prolapse	☐	☐
Artificial Valve(s)	☐	☐	Pacemaker	☐	☐
Asthma	☐	☐	Psychiatric Problems	☐	☐
Autism Spectrum	☐	☐	Radiation Treatment	☐	☐
Blood Transfusion	☐	☐	Rheumatic Fever	☐	☐
Cancer	☐	☐	Scarlet Fever	☐	☐
Chemotherapy	☐	☐	Seizures	☐	☐
Colitis	☐	☐	Sensory Processing Disorder	☐	☐
Congenital Heart Defect	☐	☐	Shingles	☐	☐
Diabetes	☐	☐	Sickle Cell Disease	☐	☐
Difficulty Breathing	☐	☐	Sinus Problems	☐	☐
Emphysema	☐	☐	Sleep Apnea	☐	☐
Epilepsy	☐	☐	Snoring	☐	☐
Fainting Spells	☐	☐	Stroke	☐	☐
Fever Blisters	☐	☐	Thyroid Problems	☐	☐
Frequent Headaches	☐	☐	Tuberculosis (TB)	☐	☐
Glaucoma	☐	☐	Ulcer	☐	☐
Hay Fever	☐	☐	Venereal Disease	☐	☐
Heart Attack	☐	☐	Hospitalized for Any Reason?		
Heart Murmur	☐	☐	Y N If yes, please explain:		
Heart Surgery	☐	☐	_____		
Hemophilia	☐	☐	_____		
Hepatitis	☐	☐	_____		
Herpes	☐	☐	_____		
High Blood Pressure	☐	☐	_____		

Please list any other medical conditions that you have had:

_____

Is pre-treatment medication necessary? Y N

Are you allergic to any of the following?

	YES	NO		YES	NO
Aspirin	☐	☐	Metal	☐	☐
Codeine	☐	☐	Penicillin	☐	☐
Dental Anesthetics	☐	☐	Plastic	☐	☐
Erythromycin	☐	☐	Tetracycline	☐	☐
Latex	☐	☐			

Please list any other drugs/materials that you are allergic to:

_____

_____

Dental History

What are the main concerns that you would like orthodontics to accomplish? _____

_____

Have you ever been evaluated for orthodontic treatment as a child or as an adult? Y N

Have you ever had a serious or difficult problem associated with any previous dental work? Y N

Do you have or have you ever experienced pain or discomfort in your jaw joint (TMJ / TMD)? Y N

Explain: _____

_____

Your current dental health is: GOOD FAIR POOR

Do you like your smile? Y N

Do your gums ever bleed? Y N

Have you ever had an injury to your: MOUTH TEETH CHIN

Do you have any speech problems? Y N

Authorizations

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the orthodontia staff to perform the necessary orthodontia services with my informed consent that I may need during diagnosis and treatment.

SIGNATURE DATE

I certify that I am covered by _____ Insurance Co. and I assign directly to Sloss & Carpenter Orthodontics all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submission, whether manual or electric.

SIGNATURE DATE

PAYMENT IS DUE AT THE TIME OF SERVICE

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

SLOSS & CARPENTER
ORTHODONTICS

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization.
In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING PROVIDERS / FACILITIES IN THE FUTURE.

_____ _____
Please ***print*** your name Please ***sign*** your name

If Patient is a minor:

_____ _____
Parent/Guardian name (please print) Parent/Guardian (please ***sign*** your name)

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.