

Please respond to all questions

Adult Health History
Geyer Orthodontics, P.C.
Specialists in Orthodontics

PATIENT'S NAME _____ Prefers to be called " _____ " Male ☐ Female ☐

Whom may we thank for referring you to our office? _____ General Dentist _____

Where & When are the best times to reach you? _____

Has anyone in the family had braces? _____ Who? _____ Were you/they pleased with the results? _____

How often do you see the dentist? _____ Date of last dental exam (Mo./Yr.) _____

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

How do you feel about the possibility of wearing orthodontic appliances? _____

Have you been evaluated for or had orthodontic treatment before?	Y	N
Are you self-conscious of your teeth?	Y	N
Have there been any injuries to your face, mouth, teeth or chin?	Y	N
Have you ever been informed of any missing or extra permanent teeth?	Y	N
Have you ever had any pain/discomfort in your jaw joint (TMJ)?	Y	N
Do you have any dental problems at this time (pain, cavities, etc.)?	Y	N
Are you apprehensive about receiving dental care?	Y	N

Have you ever had any of the following habits?

Thumb/finger sucking	Y	N	Speech problems	Y	N
Mouth breathing	Y	N	Finger nail biting	Y	N
Clenching/grinding teeth	Y	N	Tongue thrust	Y	N
Smoking	Y	N			

Are you allergic to any of the following?

Penicillin	Y	N	Nickel	Y	N
Latex	Y	N	Any other medication	Y	N

Other allergies: _____

If any of your answers are 'Y', what happens when you are exposed to the allergen? _____

MEDICAL HISTORY:

Any health problem	Y	N
Any hospitalizations	Y	N
Taking any medications	Y	N
Please list them _____		
Forceps used during your birth	Y	N
Rheumatic fever, heart disease		
heart murmur	Y	N
Latex Sensitivity	Y	N
Asthma/respiratory problems	Y	N
Prolonged bleeding or anemia	Y	N
Thyroid or hormone therapy	Y	N
Recurrent or chronic illness	Y	N

Current Physician: _____

Ulcers	Y	N
Severe headaches	Y	N
Pain of head/face	Y	N
Diabetes	Y	N
Psychiatric counseling	Y	N
Blood transfusions	Y	N
Hepatitis	Y	N
Tuberculosis	Y	N
AIDS/HIV virus	Y	N
Mouth/lip lesions (sores)	Y	N
Periodontal Disease	Y	N
Epilepsy/seizures	Y	N
Other infections	Y	N

Please explain any "Y" answers above _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my child's medical status.

Signature _____

Date _____

(OVER)

For Office Use Only

TMD HX - WNL

CL/POP

O-LOCK

C-LOCK

R

L

OTHER _____

REC TFR

POL EXP _____

DISC. _____

Patient Information

A B C

Date _____

Patient's Name _____
Last First MiddleAddress _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

Responsible Party InformationName _____
Last First Middle Marital Status E-Mail AddressResidence _____
Street City State ZipMailing Address _____
Street City State Zip

How long at this address? _____

Home Phone _____ Work Phone _____ Cell Phone _____

Previous Address (if less than 3 years) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouses Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Orthodontic Insurance Information

Policy Holder's Name _____ Soc. Sec. or Alternate ID # _____

Insurance Company _____ Group No. _____ Policy Holder's B-day _____

Insurance Co. Address _____

Policy Holder's Employer _____

Do you have dual coverage? Yes ☐ No ☐ If yes: Insurance Phone # _____

Policy Holder's Name _____ Soc. Sec. or Alternate ID # _____

Insurance Company _____ Group No. _____ Policy Holder's B-day _____

Insurance Co. Address _____

Policy Holder's Employer _____ Insurance Phone # _____

Emergency Information

Name of nearest relative not living with you _____

Complete address _____

Home Phone _____ Work Phone _____ Cell Phone _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parents signature if minor) _____

Updates (date & initial) _____

CONFIDENTIAL (for record and pretreatment evaluation)