SMITH & SMITH ORTHODONTICS

HEALTH HISTORY FORM

CONFIDENTIAL BIOGRAPHICAL INFORMATION

First Name:

Middle Initial:

Last Name:

Nickname:

Birthdate:

Gender:

Address:

City:

State:

Zip:

Main Phone:

2nd/Cell Phone:

Email:

Social Security #:

If patient is a minor, give parent's or guardian's name:

If patient is a minor, who does the patient live with?

Please list the names of any friends or family currently in the practice:

List any sports, hobbies, or musical instruments played:

Whom may we thank for referring you to our practice?

CONFIDENTIAL FINANCIAL PARTY INFORMATION

☐ **Check if the patient is also the person who will be financially responsible for treatment.**

First Name:

Middle Initial:

Last Name:

Marital Status:

Relationship to Patient:

Birthdate:

Address:

City:

State:

Zip:

How long at this address?

Previous Address (less than 3 years):

Email:

Main Phone:

2nd/Cell Phone:

Work Phone #:

Social Security #:

Employer:

Occupation:

Length of Employment:

Spouse or Other Parent's First Name:

Middle Initial:

Last Name:

Relationship to Patient:

Social Security #:

Birthdate:

Employer:

Occupation:

Length of Employment:

Work Phone #:

EMERGENCY INFORMATION

Name of nearest relative not living with you:

Complete Address:

Phone:

Relationship to Patient:

DENTAL INSURANCE INFORMATION

Policy Holder's Name:

Relationship to Patient:

Policy Holder's Employer:

Insurance Company:

Subscriber ID #

Group No.:

Insurance Co. Address:

City:

State:

Zip:

Insurance Co. Phone No.:

Policy Holder's Birthdate:

Do you have dual dental coverage?

◯ No ◯ Yes (If so, please name the Insurance Company below:)

Policy Holder's Name:

Relationship to Patient:

Policy Holder's Employer:

Insurance Company:

Subscriber ID #

Group No.:

Insurance Co. Address:

City:

State:

Zip:

Insurance Co. Phone No.:

Policy Holder's Birthdate:

As a courtesy to our patients, we will file your insurance for you so that you may more easily utilize your insurance benefits.

Important: Please notify us as soon as possible about any changes in insurance policy or coverage. To file your insurance successfully, we must have the correct insurance information on file.

Authorization:

☐ I hereby authorize Brian D. Smith, DDS, MS, PA to release any medical/dental information related to my insurance claim and/or treatment.

☐ I hereby authorize payment directly to Brian D. Smith, DDS, MS, PA of insurance benefits otherwise payable to me. I understand that I will be responsible for any portion of the orthodontic fee that my insurance does not cover.

Printed Name

Date

Signature

DENTAL HISTORY

Dentist Name:

Check-up Frequency:

Last Dental Visit:

Has the patient had an orthodontic consult or treatment? ◯ No ◯ Yes If so, when

Does the patient need to premedicate prior to dental visit? ◯ No ◯ Yes

What is the patient's main orthodontic concern?

Please select YES if the patient has had any of the conditions listed below either now or in the past.

Speech problems/therapy? ◯ No ◯ Yes

Clench or Grind Teeth? ◯ No ◯ Yes

Oral habits (thumb/finger sucking, lip/nail biting)? ◯ No ◯ Yes

Injury to face, jaw, teeth or mouth? ◯ No ◯ Yes

Discomfort from teeth or gums? ◯ No ◯ Yes

Pain, tenderness or noise in either jaw? ◯ No ◯ Yes

Frequent headaches? ◯ No ◯ Yes

Neck / Shoulder Pain? ◯ No ◯ Yes

Frequent sore throats? ◯ No ◯ Yes

Chipped or injured permanent teeth? ◯ No ◯ Yes

Teeth sensitive to hot or cold? ◯ No ◯ Yes

Previous root canal therapy? ◯ No ◯ Yes

Bad taste/mouth odor? ◯ No ◯ Yes

Previous periodontal (gum) treatment? ◯ No ◯ Yes

Abnormal swallowing (tongue thrust)? ◯ No ◯ Yes

Teeth that irritate tongue, cheek, lip, etc? ◯ No ◯ Yes

Numerous fillings? ◯ No ◯ Yes

Brush teeth daily? ◯ No ◯ Yes

Floss teeth daily? ◯ No ◯ Yes

Fluoride treatments? ◯ No ◯ Yes

Mouth breathing? ◯ No ◯ Yes

Snores during sleep? ◯ No ◯ Yes

Any missing or extra permanent teeth? ◯ No ◯ Yes

Apprehensive about dental care? ◯ No ◯ Yes

Frequently Chew Gum? ◯ No ◯ Yes

Thumb or finger habit as a child? ◯ No ◯ Yes

Jaw fractures, cysts, mouth infections? ◯ No ◯ Yes

Bleeding gums? ◯ No ◯ Yes

Other periodontal (gum) problems? ◯ No ◯ Yes

Frequent canker sores or cold sores? ◯ No ◯ Yes

Have wisdom teeth been removed? ◯ No ◯ Yes

Problems with food trapped between teeth? ◯ No ◯ Yes

Is all dental work completed? ◯ No ◯ Yes

If any of the above dental questions were answered 'Yes', please explain:

Have you had a TMJ screening? ◯ No ◯ Yes

Do you have a history of jaw joint problems? ◯ No ◯ Yes

Have you been treated for TMJ? ◯ No ◯ Yes

Do you notice clicking or popping in your jaw joint? ◯ No ◯ Yes

Do you clench your teeth? ◯ No ◯ Yes

Has your jaw ever locked? ◯ No ◯ Yes

Do you have difficulty chewing or opening your mouth? ◯ No ◯ Yes

Does your bite feel uncomfortable or unusual? ◯ No ◯ Yes

Do you experience soreness in the muscles of your face or around your ears? ◯ No ◯ Yes

If any of the above TMJ questions were answered 'Yes', please explain:

MEDICAL HISTORY

Physician Name:

Date of Last Physical:

Patient Health

Address:

City:

State:

Zip:

Has there been any change in the patient's general health within the last year?

◯ No ◯ Yes

Is the patient now under the care of a physician (other than routine)? If so, what is being treated?

◯ No ◯ Yes

Has the patient had a serious illness/hospitalization in the past 5 years? If so, what for?

◯ No ◯ Yes

List any medications currently being taken by the patient (include non-prescription):

Allergies or drug reaction to:

Latex
◯ No ◯ Yes

Penicillin or other antibiotics
◯ No ◯ Yes

Codeine or other narcotics
◯ No ◯ Yes

Aspirin, Ibuprofen, Tylenol
◯ No ◯ Yes

Local anesthetics
◯ No ◯ Yes

Other:
◯ No ◯ Yes

Latex / Metal Allergy
◯ No ◯ Yes

Sulfa drugs
◯ No ◯ Yes

List any drug allergies or sensitivities (not listed above) that the patient may have:

MEDICAL HISTORY CONTINUED

Please select YES if the patient has had any of the conditions listed below either now or in the past. Cannot be blank.

Heart Murmur
◯ No ◯ Yes

Damaged or artificial heart valves
◯ No ◯ Yes

Congenital Heart Defect
◯ No ◯ Yes

Heart Disease
◯ No ◯ Yes

Rheumatic Fever
◯ No ◯ Yes

Angina
◯ No ◯ Yes

Liver Disease / Jaundice / Hepatitis
◯ No ◯ Yes

Kidney Disease
◯ No ◯ Yes

Heart Attack / Stroke
◯ No ◯ Yes

Hemophilia
◯ No ◯ Yes

Hypertension / High Blood Pressure
◯ No ◯ Yes

Prolonged Bleeding / Transfusion
◯ No ◯ Yes

Anemia / Blood Disorder
◯ No ◯ Yes

HIV / AIDS
◯ No ◯ Yes

Tonsils / Adenoids Removed
◯ No ◯ Yes

Handicaps / Disabilities
◯ No ◯ Yes

Arthritis / Joint problems
◯ No ◯ Yes

Large Tonsils
◯ No ◯ Yes

Sinus Trouble
◯ No ◯ Yes

Bed Wetting
◯ No ◯ Yes

Substance abuse problems (past or present)
◯ No ◯ Yes

Bone fractures / Trauma to face / Jaw
◯ No ◯ Yes

Prosthetic Joints
◯ No ◯ Yes

Chronic Fatigue
◯ No ◯ Yes

Diabetes
◯ No ◯ Yes

Growth Problems
◯ No ◯ Yes

Tuberculosis or Lung Disease
◯ No ◯ Yes

Pneumonia
◯ No ◯ Yes

Cancer
◯ No ◯ Yes

Family History of Cancer
◯ No ◯ Yes

Received Radiation Treatment
◯ No ◯ Yes

Arteriosclerosis
◯ No ◯ Yes

Thyroid / Endocrine Problems
◯ No ◯ Yes

Stomach Ulcer or Hyperacidity
◯ No ◯ Yes

Hormone Therapy
◯ No ◯ Yes

Nervous Disorders
◯ No ◯ Yes

Bone Disorders/Bone Loss
◯ No ◯ Yes

Seizures / Epilepsy / Neurological Disease
◯ No ◯ Yes

Treated for Emotional Problems
◯ No ◯ Yes

Asthma
◯ No ◯ Yes

Respiratory Problems / Emphysema
◯ No ◯ Yes

Persistent swollen neck glands
◯ No ◯ Yes

Sexually Transmitted Disease
◯ No ◯ Yes

Low Blood Pressure
◯ No ◯ Yes

Persistent Cough
◯ No ◯ Yes

FEMALES: Are you pregnant?
◯ No ◯ Yes

Take Bisphosphonates (Fosamax, Boniva)
◯ No ◯ Yes

If any of the above medical questions were answered 'Yes' , please explain:

PATIENT MOTIVATION FOR ORTHODONTIC TREATMENT

Patients often request changes in their bites or faces and relief from pain or discomfort. Please help us to understand your concerns by checking the following information; please be specific (check the words - upper, lower, more, etc.)

Teeth - If your teeth could be changed, how would you like them to change?

- ☐ Straighten Front Teeth — ○ Upper ○ Lower ○ Both
- ☐ Straighten Back Teeth — ○ Upper ○ Lower ○ Both
- ☐ Move Upper Teeth — ○ Forward ○ Backward
- ☐ Move Lower Teeth — ○ Forward ○ Backward
- ☐ Eliminate Spaces Between Teeth — ○ Upper ○ Lower ○ Both
- ☐ Eliminate Crowding of Teeth — ○ Upper ○ Lower ○ Both
- ☐ Make Line of Upper Teeth More Level
- ☐ Other

Face - If your facial appearance could be changed, what would you change?

- ☐ Move Upper Lip — ○ Forward ○ Backward
- ☐ Move Lower Lip — ○ Forward ○ Backward
- ☐ Show my teeth when I smile — ○ More ○ Less
- ☐ Show my gums when I smile — ○ More ○ Less
- ☐ Make my nose: — ○ Longer ○ Shorter
- ☐ Move chin: — ○ Forward ○ Backward
- ☐ Move chin: — ○ Left ○ Right
- ☐ Reduce the strain when I close my lips in my: — ○ Chin ○ Lips ○ Both
- ☐ When my teeth touch make my lips: — ○ Closer ○ Together ○ Farther Apart
- ☐ Get rid of sag under lower jaw

Symptoms - If you want to reduce pain or discomfort, please be specific about its location; check the right or left side or both if they apply.

- ☐ My teeth
- ☐ My sinuses
- ☐ In front of ears — ○ Left ○ Right ○ Both
- ☐ Below ears — ○ Left ○ Right ○ Both
- ☐ Above ears — ○ Left ○ Right ○ Both
- ☐ In my ears — ○ Left ○ Right ○ Both
- ☐ My temples — ○ Left ○ Right ○ Both
- ☐ My eyes — ○ Left ○ Right ○ Both
- ☐ My neck — ○ Left ○ Right ○ Both
- ☐ My shoulders — ○ Left ○ Right ○ Both
- ☐ My jaw joints — ○ Left ○ Right ○ Both
- ☐ Other:

PATIENTS UNDER 18

If patient is under the age of 18, please answer the following questions:

Height: | Weight: | School: | Grade:

Has patient begun puberty:
◯ No ◯ Yes

If patient is a girl, has menstruation begun:
◯ No ◯ Yes

If patient is a boy, has their voice changed or have facial hair:
◯ No ◯ Yes

Has the patient grown in the past year or has their shoe size changed recently:
◯ No ◯ Yes

Has either biological parent ever had orthodontic treatment:
◯ No ◯ Yes ◯ I don't know

☐ I certify that I have read and understand the above. I acknowledge that I have completed this form to the best of my knowledge, and that my questions have been answered to my satisfaction. I will not hold my orthodontist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there is any change later to this history record or medical or dental status, I will inform the practice.

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

Printed Name

Date

Signature

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient:

Birthdate:

Smith and Smith Orthodontics is authorized to release protected health information about the above named patient in the following manner and to persons listed.

List each person/entity that you approve to recieve information.	**Check the type of information that the person/entity (listed on left) may receive.**
Voicemail	◯ Results of lab tests/x-rays ◯ Other:
Spouse (name and phone number)	◯ Financial ◯ Medical
Parent (name and phone number)	◯ Financial ◯ Medical
Email address*	◯ Financial ◯ Appointment reminders ◯ Medical ◯ Breach notification

***I understand that non-encrypted email communication could be accessed inappropriately. I still elect to allow email communications.**

Patient rights:

I have the right to revoke this authorization at any time. I may inspect or copy the protected health information to be disclosed as described in this document. Revocation is not effective in cases where the information has already been disclosed, but will be effective going forward. Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

Signature of Patient or Personal Representative

Date

*Description of Personal Representative's Authority (attach necessary documentation)

REWARDING PATIENTS FOR A JOB WELL DONE!

Photography release

We like to recognize our patients and reward them for winning in-office contests, achievements in school, athletics, community activities, as well as the work they do maintaining their braces by keeping them clean and intact. During the course of treatment, we may want to post a photograph in the office or on our Facebook page. We do this to engage our patients and reward them for a job well done. I hereby give my permission for my child's photograph to be posted in the office of Dr. Brian Smith and Dr. Lynn Smith, and/or for my child's photograp to be posted electronically on the Facebook page and/or website of Dr. Brian Smith and Dr. Lynn Smith.

Patient's Name

Parent/Guardian Name

Parent/Guardian Signature

Date