American Association of Orthodontists®

My Life. My Smile. My Orthodontist.®

CONFIDENTIAL

Medical Dental History Form for Adult Patients

Patient

Date _____

Patient's last name _____ First name _____ Middle initial _____

Title ☐Mr.☐Mrs☐Ms☐Miss☐Dr. Other _____ I prefer to be called _____

Birth date _____ Sex ☐ Male ☐ Female Social Security # _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home address _____ City, State, Zip code _____

Home phone ( ) _____-_____ Cell phone ( ) _____-_____ Work phone ( ) _____-_____

Email Address(es) _____

Occupation _____ Employer _____

Closest Relative

Spouse or closest relatives name(s) _____

Title ☐Mr.☐Mrs☐Ms.☐Miss☐Dr. Other _____ Relationship to patient _____

Address *(if different than patient address)* _____

Home Phone *(If different)* ( ) _____-_____ Cell phone ( ) _____-_____ Work phone ( ) _____-_____

Dentist

Patient's Dentist _____ Address, City, State _____

Last seen _____ Reason _____ Next appointment _____

Other dentists/dental specialists now being seen: Name _____ City, State _____

Reason _____

Physician

Patient's Physician _____ City, State _____

Last seen _____ Reason _____ Next appointment _____

Most recent physical exam _____

Other physicians/health care providers being seen now:

Name _____ City, State _____

Reason _____

Name _____ City, State _____

Reason _____

General Information

What concerns you about your teeth? _____

Who suggested that you might need orthodontic treatment? _____

Why did you select our office? _____

Have you had any previous orthodontic treatment? Please describe. _____

Have any other family members been treated in this office? Please name them. _____

Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain. _____

_____

Financial Responsibility

Who is financially responsible for this account? _____

Address *(if different than page 1)* _____ City, State, Zip _____

Home phone ( ) _____-_____ Cell phone ( ) _____-_____ Email address(es) _____

Social Security # _____ Employer _____

Dental Insurance

Primary policy holder's full name _____ Birth date _____

Social Security # _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID# _____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

Secondary policy holder's full name _____ Birth date _____

Social Security # _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID# _____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

Medical Insurance

Policy holder's full name _____

Insurance Company _____

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation.

For the following questions, please mark yes, no, or don't know/understand (dk/u).

Medical History

Now or in the past, have you had:

Yes No DK/U

- ☐ ☐ ☐ Birth defects or hereditary problems?
- ☐ ☐ ☐ Bone fractures or major injuries?
- ☐ ☐ ☐ Any injuries to face, head, neck?
- ☐ ☐ ☐ Arthritis or joint problems?
- ☐ ☐ ☐ Endocrine or thyroid problems?
- ☐ ☐ ☐ Diabetes or low sugar?
- ☐ ☐ ☐ Kidney problems?
- ☐ ☐ ☐ Cancer, tumor, radiation treatment or chemotherapy?
- ☐ ☐ ☐ Stomach ulcer, hyperacidity, acid reflux?
- ☐ ☐ ☐ Immune system problems?
- ☐ ☐ ☐ History of osteoporosis?
- ☐ ☐ ☐ Gonorrhea, syphilis, herpes, sexually transmitted diseases?
- ☐ ☐ ☐ AIDS or HIV positive?
- ☐ ☐ ☐ Hepatitis, jaundice, or other liver problems?
- ☐ ☐ ☐ Polio, mononucleosis, tuberculosis, pneumonia?
- ☐ ☐ ☐ Seizures, fainting spells, neurologic problems?
- ☐ ☑ ☐ Mental health disturbance or depression?
- ☐ ☐ ☐ Vision, hearing, or speech problems?
- ☐ ☐ ☐ History of eating disorder (anorexia, bulimia)?
- ☐ ☐ ☐ High or low blood pressure?
- ☐ ☐ ☐ Excessive bleeding or bruising, anemia?
- ☐ ☐ ☐ Chest pain, shortness of breath, tire easily, swollen ankles?
- ☐ ☐ ☐ Heart defects, heart murmur, rheumatic heart disease?
- ☐ ☐ ☐ Angina, arteriosclerosis, stroke or heart attack?
- ☐ ☐ ☐ Skin disorder (other than common acne)?
- ☐ ☐ ☐ Do you eat a well-balanced diet?
- ☐ ☐ ☐ Frequent headaches or migraines?
- ☐ ☐ ☐ Frequent ear infections, colds, throat infections?
- ☐ ☐ ☐ Asthma, sinus problems, hayfever?
- ☐ ☐ ☐ Tonsil or adenoid condition?
- ☐ ☐ ☐ Do you frequently breathe through your mouth?

Have you had allergies or reactions to any of the following?

Yes No DK/U

- ☐ ☐ ☐ Local anesthetics (novocaine, lidocaine, xylocaine)
- ☐ ☐ ☐ Latex (gloves, balloons)
- ☐ ☐ ☐ Aspirin
- ☐ ☐ ☐ Metals (jewelry, clothing snaps)
- ☐ ☐ ☐ Penicillin
- ☐ ☐ ☐ Other antibiotics
- ☐ ☐ ☐ Ibuprofen (Motrin, Advil)
- ☐ ☐ ☐ Acrylics
- ☐ ☐ ☐ Plant pollens
- ☐ ☐ ☐ Animals
- ☐ ☐ ☐ Foods
- ☐ ☐ ☐ Other substances _____

Dental History

Now or in the past, have you had:

Yes No DK/U

- ☐ ☐ ☐ Permanent or extra (supernumerary) teeth removed?
- ☐ ☐ ☐ Supernumerary (extra) or congenitally missing teeth?
- ☐ ☐ ☐ Chipped or injured primary or permanent teeth?
- ☐ ☐ ☐ Any sensitive or sore teeth?
- ☐ ☐ ☐ Bleeding gums, bad taste or mouth odor?
- ☐ ☐ ☐ Jaw fractures, cysts, infections?
- ☐ ☐ ☐ Any teeth treated with root canals or pulpotomies?
- ☐ ☐ ☐ "Gum boils," frequent canker sores or cold sores?
- ☐ ☐ ☐ History of speech problems or speech therapy?
- ☐ ☐ ☐ Difficulty breathing through nose?
- ☐ ☐ ☐ Food impaction between the teeth?
- ☐ ☐ ☐ Mouth breathing habit or snoring at night?
- ☐ ☐ ☐ Frequent oral habits (sucking finger, chewing pen, etc)?
- ☐ ☐ ☐ Teeth causing irritation to lip, cheek or gums?
- ☐ ☐ ☐ Abnormal swallowing (tongue thrust)?
- ☐ ☐ ☐ Tooth grinding or clenching?
- ☐ ☐ ☐ Clicking, locking in jaw joints?
- ☐ ☐ ☐ Soreness in jaw muscles or face muscles?
- ☐ ☐ ☐ Ringing in ears, difficulty in chewing or opening jaw?
- ☐ ☐ ☐ Have you ever been treated for "TMJ" or "TMD" problems?
- ☐ ☐ ☐ Any broken or missing fillings?
- ☐ ☐ ☐ Any serious trouble associated with previous dental treatment?
- ☐ ☐ ☐ Have you ever been diagnosed with gum disease or pyorrhea?
- ☐ ☐ ☐ Have you ever had an orthodontic consultation or treatment before now?

Patient Health Information

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements, that you take.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Have you ever taken any medications to strengthen your bones? Please describe._____

_____

Do you take antibiotic pre-medication before any dental procedures? _____

Do you or have you ever had a substance abuse problem? _____

Do you chew or smoke tobacco? _____

Have you noticed any changes in your face or jaws? _____

Any other physical problems? _____

How often do you brush? _____ How often do you floss? _____

Women: Are you pregnant? ☐ Yes ☐ No Are you trying to become pregnant? ☐ Yes ☐ No

Family Medical History

Have your parents or siblings ever had any of the following health problems? If so, please explain._____

Bleeding disorders _____ Diabetes _____

Arthritis _____ Severe allergies _____

Unusual dental problems _____ Jaw size imbalance _____

Other family medical conditions? _____

_____

Release and Waiver

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature _____ Date _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature _____ Date _____

Medical History Updates or Changes

Changes _____

Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Signature _____ Date _____

Dental Staff Signature _____ Date _____

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Form 14-200F3

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practice, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a dentist or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs accreditation, certification, licensing or credentialing activities.

Your authorization: In addition to our use of your health information for treatment, payment or healthcare operations you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To our family and friends: We must disclose you health information to you, as described in the Patient Rights section to this Notice. We may disclose your health information to a family member, friend or other person that is necessary to help with your healthcare or with payment for you healthcare, but only if you agree that we may do so.

Persons involved in care: We may use or disclose health information to notify, or assist in the notification of (Including identifying or locating) a family member, your personal representative or another person responsible for your care, or your location your general condition or death. If you arc present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of you incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up x-rays or other similar forms of health information.

Marketing Health-Related services: We will not use your health for marketing communication without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, First:_____Last:_____, have received a copy of this office's Notice of Privacy Practices.

_____ _____
Please Print Responsible Party Name Patient Name

_____ _____/_____/_____
Responsible Party Signature Date

Submit

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)