Grosman
Pediatric Dentistry & Orthodontics

ADULT MEDICAL HISTORY FORM

Today's Date: _____
Patient's Name: _____
Last First MI

Sex: M F I prefer to be called: _____ SS#: _____

Home Address_____ _____
Street City State Zip Home #

Marital Status (circle one): Single Widowed Separated Married Divorced

DOB: _____ Employer: _____Occupation: _____
Cell #: _____ Work #: _____ **E-mail**: _____

Employer address:
_____
How long there? _____ Where & when are best times to reach you? _____
Our family members seen by us? _____

Person Responsible For Account

Name: _____
Billing Address:_____
Street City State Zip

DOB:_____ Employer:_____ Home #:_____
Cell #_____ Work #: _____ **E-mail**: _____
SS #:_____ Driver's License #: _____

Insurance Information

Insured's Name: _____ Insurance Co.:_____
Group #: _____ Insured's Employer: _____
Do you have orthodontic insurance? Yes No Don't Know
Any Secondary Insurance for Orthodontics? _____

Whom may we Thank for referring you? _____

Medical History

Your current health is : ( ) Good ( ) Fair ( ) Poor
Are you currently under the care of a physician? ( ) Yes ( ) No
Please explain: _____
Are you taking any prescriptions/over the counter drugs? ( ) Yes ( ) No
Please list each one: _____

1) Have you ever had any of the following diseases or medical problems? **(circle all that apply):**

Asthma	Cancer	HIV +/ AIDS	Hospitalized for any reason
Anemia/Radiation Treatment	Blood Disease	Mitral Valve Prolapse	Epilepsy
Artificial Valves	Learning Problems	Psychiatric Problems	Kidney Infections
Arthritis	Mumps	Seizures	Mental Conditions
Blood Transfusions	Rheumatic/Scarlet Fever	Diabetes	Sight Problems
Fever Blisters/Herpes	Chicken Pox	Emphysema/Glaucoma	Spleen Problems
Heart Attack/ Stroke	Hearing Problems	Hemophilia	Venereal Disease
Heart Surgery/Pacemaker	Liver Problems	Abnormal Bleeding	Shingles
Hepatitis	Kidney Problems	Tumors	Ulcers/ Colitis

2. Are you allergic to any of the following? **(circle all that apply):**

Aspirin **Penicillin** **Tetracycline**
Any metal / plastic **Dental Anesthetics**
Latex **Erythromycin**
Other: _____ Foods: _____

3. Have you ever been told you require **Antibiotic pre-medication** prior to a dental appointment? Yes No
If so, why? _____

For Women:
Are you taking birth control? ( ) Yes ( ) No Are you pregnant? ( ) Yes ( ) No Are you nursing? ( ) Yes ( ) No

Dental / Orthodontic History

Your Current Dentist:_____
What are your main concerns that you would like the orthodontist to accomplish?
_____
_____

1. Have you **ever been evaluated for or had any orthodontic treatment?** Yes No
2. Have you ever had any pain/tenderness in his/her jaw joint (TMJ/TMD) Yes No
3. Have you ever had serious problems associated with any previous dental work? Yes No
4. Do you like your smile? Yes No
5. Do your gums ever bleed? Yes No
6. Have there been any injuries to the face, mouth, teeth or chin? Yes No
   If so, describe & when:_____
7. Are you aware of having **any extra and/or missing teeth?** Yes No
   _____
8. Have the following been removed: Tonsils or Adenoids (circle all that apply) Yes No
9. Do you have any speech problems? Yes No
10. Do you generally breathe through your MOUTH: ( ) Awake ( ) Asleep ?

Do you know of any other family member or friend who would benefit from orthodontic treatment?

Name	Phone Number
_____	_____
_____	_____
_____	_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes to my medical status. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may at the discretion of this office, use the services of one or more credit reporting services.

I authorize the dental staff to perform the necessary dental services I may need.

_____ _____ _____
Patient Signature Relationship to Patient Date

I have reviewed the health questionnaire with the patient.

_____
Signature of Dentist Date

I. CONSENT FOR OFFICE AND FINANCIAL POLICIES:

I, as the Financially Responsible Person/ Parent/ Guardian for this account, certify that I have read, understand, and agree to Grosman Pediatric Dentistry & Orthodontics' payment and office policies.

SIGNATURE OF PATIENT PRINT NAME OF PERSON SIGNING DATE

II. ACKNOWLEDGEMENT OF FEE FOR BROKEN APPOINTMENTS:

I understand that if I do not give proper notice to cancel my appointment, or that if I fail to show up for a scheduled appointment without notice, I will be charged a "broken appointment " fee. We reserve the right to charge **$30.00 for a recall (cleaning) appointment and $60.00 for a restorative (filling) appointment or the maximum allowed by my dental plan for any appointment cancelled w/o 24hrs notice .(appts cannot be cancelled on the weekends). ALL SCHOOL DAYS OFF OR ½ DAYS WILL REQUIRE $30.00 PRE PAY.**

SIGNATURE OF PATIENT PRINT NAME OF PERSON SIGNING DATE

III. CONSENT TO THE USE, DISCLOSURE AND REQUEST OF HEALTH INFORMATION FOR TREAMENT, PAYMENT OR HEALTHCARE OPERATIONS AND ACKNOWLEDGEMENT OF THE OPPORTUNITY TO READ AND/OR RECEIVE THE HEALTH INFORMATION PRIVACY PRACTICES:

I FULLY UNDERSTAND AND AGREE TO THIS CONSENT AND ACKNOWLEDGE MY RIGHTS AND DISCLOSURES.

SIGNATURE OF PATIENT PRINT NAME OF PERSON SIGNING DATE

*IF OTHER THAN PATIENT IS SIGNING, ARE YOU THE PARENT, LEGAL GUARDIAN, LEGAL CUSTODIAN OR HAVE POWER OF ATTORNEY FOR TREATMENT AND/OR PAYMENT FOR THIS PATIENT?
YES { } NO { }
RELATIONSHIP_____ IF YOU ARE NOT THE PARENT, PLEASE PROVIDE A COPY OF YOUR LEGAL AUTHORITY FOR THIS PATIENT.

*This signed form will be scanned and retained by our office as the legal record. We will provide a copy of this form or manual upon request.