Simi Children's Dental Group
ORTHODONTICS For Children and Adults

Adult Health History Form

Date _____

Patient's name _____ Date of birth _____ ○ Male ○ Female
LAST FIRST MI

Address _____ Phone _____
STREET CITY STATE ZIP

Cell phone _____ Email _____

Employer _____ Occupation _____

Work address _____
STREET CITY STATE ZIP

Work phone _____

Insurance Co. _____ Group No. _____ SSN or ID No. _____

Patient's dentist _____ Patient's physician _____

Referred By _____

Spouse's Information

Spouse's name _____ Date of birth _____
LAST FIRST MI

Employer _____ _____

Work address _____
STREET CITY STATE ZIP

Work phone _____

Insurance Co. _____ Group No. _____ SSN or ID No. _____

Medical History

Are you in good health? ○ Yes ○ No

Do you have any history of major illness? ○ Yes ○ No

Have you ever been treated for an illness? ○ Yes ○ No

Check any of the following for which you have been treated:

- ○ Diabetes
- ○ Pneumonia
- ○ Heart trouble
- ○ Rheumatic fever
- ○ Bone disorder
- ○ Herpes
- ○ Anemia
- ○ Epilepsy
- ○ Asthma
- ○ Kidney involvement
- ○ Tuberculosis
- ○ AIDS
- ○ Prolonged bleeding
- ○ Fainting/dizziness
- ○ Nervous disorders
- ○ Liver involvement
- ○ Endocrine problems
- ○ Other: _____

Have your tonsils/adenoids been removed? ○ Yes ○ No
If so, at what age? _____

List any drugs/medications you are taking or have recently taken, including Fosamax, and for what reasons:

_____

_____

_____

List any allergy or sensitivity to medications or drugs including Penicillan, Aspirin, Novacain, Latex or Nickel

_____

_____

Are you currently under the care of a physician? ○ Yes ○ No
If so, for what? _____

Dental History

Have there been any injuries to your face/mouth/teeth? ○ Yes ○ No

Do you have any speech problems? _____ ○ Yes ○ No

Are you a mouth-breather? ○ Yes ○ No
While awake? ○ Yes ○ No
While asleep? ○ Yes ○ No

Do you have any missing teeth? ○ Yes ○ No

Do you have any extra permanent teeth? ○ Yes ○ No

Has an orthodontist been consulted? ○ Yes ○ No

Has any member of your family had previous orthodontic treatment? _____

Reason for consultation: _____

_____

I have read and I understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form.

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 later changes to this history record or medical/dental status.

_____ _____
Signature Date

Medical History Updates or Changes

Date: _____
Comments: _____
_____
_____
Initial: _____

Date: _____
Comments: _____
_____
_____
Initial: _____

Date: _____
Comments: _____
_____
_____
Initial: _____

Date: _____
Comments: _____
_____
_____
Initial: _____

Thank you for filling out this form completely. It will enable us to provide you with better orthodontic care.