The Smile Agency/Karen Guinn D.D.S., Inc.
MEDICAL/DENTAL HISTORY FORM

ALL INFORMATION IS KEPT CONFIDENTIAL

Please fill out form completely

Whom may we thank for referring you to our office: ______________________ PIN#_______

Patient Information: Who suggested that you might need orthodontic treatment? ____________________________________

First Name: ___________________________ Last Name: ___________________________ Nick Name: ________________

Birth Date: ______________ Age: ______ Address: ____

City: _____________________________________ State: __________ Zip: ___________Years at address: ______

Home #.______________________ Cell # _______________________ Work or Alt. Contact #: ______________________

D.L.# ________________________ S.S.N: _________________________ Male ◻ Female ◻ Patient is: Child ◻ Adult ◻

Email address: ______________________________________ School:____

Emergency Contact: ____________________________ Relationship : _____________Phone No: ______________________

Parent/ Responsible Party Information: Relationship to patient: _________________________

Name: ______________________________________ D.O.B _____________________ D.L.# _______________________

Phone: _____________________ Email Address _______________________________ SSN.:________________________

Address____

Home #.______________________ Cell # _______________________ Work or Alt. Contact #: ______________________

Secondary Parent/Responsible Party: Relationship to patient: _________________________

Name: ______________________________________ D.O.B _____________________ D.L.# _______________________

Phone: _____________________ Email Address _______________________________ SSN.:________________________

Address____

Home #.______________________ Cell # _______________________ Work or Alt. Contact #: ______________________

Patient Dental Information: **PLEASE ENTER ALL FIELDS**

Office Name __________________________________ Doctor name __________________Phone _____________________

Address: ____Rm./Suite #: ________

Last Cleaning______________ Last Check up __________Reason: ____

Insurance Information: Coverage for Dental Treatment? Yes ◻ No ◻ Coverage for Orthodontic Treatment? Yes ◻ No ◻

Dental Insurance Company: __________________________________ Effective date: _____________Group #.: ______________

Policy Holder Name: ____ Birth Date: ______________________

S.S.N/Enrollee #: _________________________ Employer ____

Secondary Insurance: Coverage for Dental Treatment? Yes ◻ No ◻ Coverage for Orthodontic Treatment? Yes ◻ No ◻

Dental Insurance Company: __________________________________ Effective Date: _____________Group #.:______________

Policy Holder Name: ____ Birth Date: ______________________

S.S.N/Enrollee #: _________________________ Employer____

Medical Information: Enrollee Name: ____

Medical Insurance Company: ____________________________ Enrollee I.D. #______________________________

Name of Patient's Physician: ___________________________________ Phone No: ___________________________

Date Last Seen: ____________________ Reason: __________++____

For the following questions mark yes, no, or don't know/understand (dk/u). The answers are for office records only and are confidential. A complete history is vital to an orthodontic evaluation.

MEDICAL HISTORY

Now or in the past, have you had:

yes □ no □ ? □ Birth defects or hereditary problems?
yes □ no □ ? □ Bone fractures, any major accidents?
yes □ no □ ? □ Rheumatoid or arthritic conditions?
yes □ no □ ? □ Endocrine or thyroid problems?
yes □ no □ ? □ Kidney problems?
yes □ no □ ? □ Diabetes?
yes □ no □ ? □ Cancer, tumor, radiation treatment or chemotherapy?
yes □ no □ ? □ Stomach ulcer or hyperacidity?
yes □ no □ ? □ Polio, mononucleosis, tuberculosis, pneumonia?
yes □ no □ ? □ Problems of the immune system?
yes □ no □ ? □ AIDS or HIV positive?
yes □ no □ ? □ Hepatitis, jaundice or liver problem?
yes □ no □ ? □ Fainting spells, seizures, epilepsy or neurological problem?
yes □ no □ ? □ Mental health disturbance or depression?
yes □ no □ ? □ Vision, hearing, tasting or speech difficulties?
yes □ no □ ? □ Loss of weight recently, poor appetite?
yes □ no □ ? □ History of eating disorder (anorexia, bulimia)?
yes □ no □ ? □ Excessive bleeding or bruising tendency, anemia or bleeding disorder?
yes □ no □ ? □ High or low blood pressure?
yes □ no □ ? □ Tired easily?
yes □ no □ ? □ Chest pain, shortness of breath or swelling ankles?
yes □ no □ ? □ Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
yes □ no □ ? □ Skin disorder?
yes □ no □ ? □ Do you have a well-balanced diet?
yes □ no □ ? □ Frequent headaches, colds or sore throats?
yes □ no □ ? □ Eye, ear, nose or throat condition?
yes □ no □ ? □ Hay fever, asthma, sinus trouble or hives?
yes □ no □ ? □ Tonsil or adenoid conditions?
yes □ no □ ? □ Osteoporosis?
yes □ no □ ? □ Sleep Apnea? (Stop breathing when sleeping)

ALLERGIES OR REACTIONS RO ANY OF THE FOLLOWING

yes □ no □ ? □ Local anesthetics (Novacaine or Lidocaine)
yes □ no □ ? □ Aspirin
yes □ no □ ? □ buprofen (Motrin, Advil)
yes □ no □ ? □ Penicillin or other antibiotics
yes □ no □ ? □ Sulfa drugs
yes □ no □ ? □ Codeine or other narcotics
yes □ no □ ? □ Metals (jewelry, clothing snaps)
yes □ no □ ? □ Latex (gloves, balloons)
yes □ no □ ? □ Vinyl
yes □ no □ ? □ Acrylic
yes □ no □ ? □ Animals
yes □ no □ ? □ Foods (specify) ____________________________
yes □ no □ ? □ Other substances (specify) ____________________

Yes □ no □ ? □ Are you taking medication, nutrient supplements, herbal medications or non Prescription medicine?

Medication ____________________Taken for ______________
Medication ____________________Taken for ______________
Medication ____________________Taken for ______________
Medication ____________________Taken for ______________
Medication ____________________Taken for ______________
Medication ____________________Taken for ______________
Medication ____________________Taken for ______________

yes □ no □ ? □ Do you have or ever had a substance abuse problem?
yes □ no □ ? □ Do you chew or smoke tobacco?
yes □ no □ ? □ Operations?
Describe: ____
yes □ no □ ? □ Hospitalized?
Describe: ____
yes □ no □ ? □ Other physical problems or symptoms?
Describe: ____
yes □ no □ ? □Being treated by another health care Professional? For: ____________________
Date of most recent physical exam? __________________________
Do you have any other medical conditions that we should know about?
____

WOMEN ONLY

yes □ no □ ? □ Are you pregnant?
yes □ no □ ? □ Are you anticipating becoming pregnant?

FAMILY MEDICAL HISTORY

Do your parents or siblings have, or have ever had any of the following health problems? If so, explain.

Bleeding disorders ____________________________________
Diabetes ____
Arthritis ____
Severe allergies _______________________________________
Unusual dental problems ________________________________
Jaw size imbalance ____________________________________
Any other family medical conditions that we should know about?
____
____
____

Doctor Reviewed ______

DENTAL HISTORY

Now or in the past, has the patient had:

yes □ no □ unsure □ Permanent or "extra" (supernumerary) teeth removed?
yes □ no □ unsure □ Supernumerary (extra) or congenitally missing teeth?
yes □ no □ unsure □ Chipped or otherwise injured primary (baby) or permanent teeth?
yes □ no □ unsure □ Teeth sensitive to hot or cold; teeth throb or ache?
yes □ no □ unsure □ Jaw fractures, cysts or mouth infections?
yes □ no □ unsure □ Dead teeth or root canals treated?
yes □ no □ unsure □ Bleeding gums, bad taste or mouth odor?
yes □ no □ unsure □ Periodontal "gum problems"?
yes □ no □ unsure □ Food impaction between teeth?
yes □ no □ unsure □ "Gum boils", frequent canker sores or cold sores?
yes □ no □ unsure □ Thumb, finger, or sucking habit? Until what age? ____________
yes □ no □ unsure □ Abnormal swallowing habit (tongue thrusting)?
yes □ no □ unsure □ Mouth breathing habit, snoring or difficulty in breathing?
yes □ no □ unsure □ Tooth grinding or jaw clenching?
yes □ no □ unsure □ Any pain, clicking or locking in jaw or ringing in ears?
yes □ no □ unsure □ Any pain or soreness in the muscles of the face or around the ears?
yes □ no □ unsure □ Difficulty in chewing or jaw opening?
yes □ no □ unsure □ Have you ever been treated for "TMD" or "TMJ" problems?
yes □ no □ unsure □ Aware of loose, broken or missing restorations (fillings)?
yes □ no □ unsure □ Any teeth irritating cheek, lip, tongue or palate?
yes □ no □ unsure □ Concerned about spaced, crooked or protruding teeth?
yes □ no □ unsure □ Aware or concerned about under or over developed jaw?
yes □ no □ unsure □ Any relative with similar tooth or jaw relationships?
yes □ no □ unsure □ Any wisdom tooth problems?
yes □ no □ unsure □ Had periodontal (gum) treatment?
yes □ no □ unsure □ Had any serious trouble associated with any previous dental treatment?
yes □ no □ unsure □ Been under another dentist's care? Specialist ____________ Other____________
yes □ no □ unsure □ Ever had a prior orthodontic examination or treatment?
yes □ no □ unsure □ Would you object to wearing orthodontic appliances (braces) should they be indicated?

How often do you brush per day: ____________ How often do you floss per day? ____________

Doctor Reviewed ________ Initials

Chief Concern and what would you like to see change:

____

____

I have read and understand the above questions. 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. If there are any future changes to this history record or medical/dental status, I will inform this practice to update my record. I also authorize and request my insurance company to pay directly to the orthodontist or dental group, my insurance benefits that can be otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits or outstanding balance on my account. I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I also understand that where appropriate, credit bureau reports may be obtained.

Signed: ____ Date Signed: ____________________
(Patient or Parent/Guardian responsible)

Signed: ____ Date Signed: ____________________
(Witness - Dental staff member or Doctor)