Burke Orthodontics

Name ____________________

ID No. ____________________

Confidential Adult Patient Health History and Information Page 1

Confidential Patient Information

Patient'sName: ______________________________ Gender: M F
last *first* *middle*

Address: ______________________________
street *city* *state* *zip*

Home Phone: __________ Birthdate: __________ Social Security No.: __________

Whom may we thank for referring you to our office?: ______________________________

Confidential Responsible Party Information

Date __________

Name: ______________________________ Marital Status: __________
last *first* *middle*

Residence: ______________________________ Own: ______ Rent: ______
street *city* *state* *zip*

Billing Address: ______________________________
street *city* *state* *zip*

How long at this address: ______ Home Phone: __________ Work Phone: __________

Cell Phone: __________ Email/Text: __________ May we email or text an appt. reminder? __________

Previous Address (if less than 3 years): ______________________________
street *city* *state* *zip*

Social Security No.: __________ Birthdate: __________ Relationship to Patient: __________

Employer: __________ Occupation: __________ Military Pay Grade: ______ No. Years Employed: ______

Spouse's Name: ______________________________ Relationship to Patient: __________
last *first* *middle*

Employer: __________ Occupation: __________ Military Pay Grade: ______ No. Years Employed: ______

Social Security No.: __________ Birthdate: __________ Work Phone: __________

Cell Phone: __________ Email/Text: __________ May we Email or Text an appt. reminder?: __________

Insurance Information

Policy Holder's Name: ______________________________ D.O.B: ______ Social Security No.: __________

Insurance Company: ______________________________ Group No.: ______ Union Local No.: __________

Insurance Company Address: ______________________________ Insurance Co. Phone: __________

Policy Holder's Employer: ______________________________

Do you have dual coverage?: Yes/No If yes, Policy Holder's Name: ______________________________

Social Security No.: __________ Insurance Company: ______________________________

Group No.: ______ Union Local No.: ______ Insurance Co. Address: ______________________________

Insurance Co. Phone: __________ Policy Holder's Employer: ______________________________

Emergency Contact Information

Name of Emergency Contact: ______________________________ Relationship: __________

Address: ______________________________ Phone: __________
street *city* *state* *zip*

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

Signature: ______________________________

Updates (date & initial): __________ *Dr.* ______ *Tech* ______

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Confidential Adult Patient Health History and Information
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Adult Patient Dental History Information

What is your main orthodontic problem as you see it? ______________________

Are you sensitive about the appearance of your teeth or facial features (nose, chin, lips, etc)? ______________________

Are you interested in Traditional Braces? ______________________

Have you had an orthodontic consultation? Yes _____ No_____ If yes, when? ______________________

Has anyone in the family received orthodontic treatment from Burke Orthodontics? Yes _____ No _____

If yes, who? ______________________

Name of your current general dentist: ______________________ How many years? __________

Name of previous general dentist: ______________________

Frequency of dental checkups? ______________________ Date of last dental exam: ______________________

Are there any needed restorations? Yes _____ No _____

Date of restorations will be completed? ______________________

Please check any of the following that apply and explain in the box below

❍ Are you apprehensive about dental care?
❍ Have you had any trouble associated with dental treatment?
❍ Have you had any teeth extracted?
❍ Have you ever injured or broken any teeth?
❍ Do you have any discomfort from teeth?
❍ Do you have any missing teeth?
❍ Do you have any extra teeth?
❍ Do you habitually grind or clench teeth?
❍ Do you receive regular fluoride treatment?
❍ Do you have discomfort from gums?
❍ Do you have frequent canker sores?
❍ Are you aware of any swellings or growths in your mouth?
❍ Do you breathe with your mouth open or lips parted?
❍ Have you been referred or are you being treated by a dental specialist?
❍ Have you had any injuries to your face or mouth?
❍ Have you had any injuries to either jaw?
❍ Do you suck on your fingers or thumb?
❍ Do you chew on other objects such as pens?
❍ Do you have regular jaw pain?
❍ Do you have limited jaw movement?
❍ Do your jaws click or pop?
❍ Do you have any trouble eating, chewing or swallowing?
❍ Are you in speech therapy currently?

If you have checked any of the above, please explain:

Dr. _______ *Tech* ________

Burke Orthodontics

Name ____________________

ID No. ____________________

Adult Patient Medical History Information

Name & Location of Physician: ______________________________ Are You in Good Health: __________

Date of last physical: __________ Are you presently under the care of a physician for any illness? __________ Please specify below.

Do you have a history of major illness or been hospitalized? ______________________________ Please specify below.

Is there anything you would like to talk to the doctor about in private? ______________________________

Please Check any of the following that apply to the patient and explain in the box below

- ❍ Have you seen a medical specialist?
- ❍ Do you have a tendency to catch colds?
- ❍ Do you have an allergy to latex?
- ❍ Do you have an allergy to metals?
- ❍ Do you have any drug allergies/sensitivities?
- ❍ Do you require pre-medications?
- ❍ Are you taking any drugs or medications?
- ❍ Have you ever received Bisphosphonate treatment or other bone building medications? *(e.g. Fosamax, Actinol, Boniva)*
- ❍ Do you have gastric reflux?
- ❍ Are you pregnant or breast feeding?

Please check any of the following for which the patient has been treated and explain in the box below

- ❍ AIDS/HIV?
- ❍ Asthma?
- ❍ Arthritis?
- ❍ Artificial joints?
- ❍ Bone disorders?
- ❍ Cancer?
- ❍ Cerebral palsy?
- ❍ Diabetes?
- ❍ Emotional problems?
- ❍ Endocrine problems?
- ❍ Fainting or dizziness?
- ❍ Frequent headaches or neck aches?
- ❍ Heart trouble *(i.e. congenital heart defect, murmurs)*
- ❍ Hepatitis?
- ❍ Hormone therapy?
- ❍ Jaundice?
- ❍ Kidney problems?
- ❍ Liver problems?
- ❍ Low/high blood pressure?
- ❍ Multiple sclerosis?
- ❍ Nervous disorders?
- ❍ Osteoporosis?
- ❍ Prolonged bleeding?
- ❍ Rheumatic Fever?
- ❍ Sickle cell anemia?
- ❍ Sleep Apnea/Snoring?
- ❍ Stomach ulcers?
- ❍ Tuberculosis?
- ❍ Thyroid problems?
- ❍ Unusual growth patterns?

If you have checked any of the above, please explain:

I authorize the release of any necessary dental or medical records to Burke Orthodontics for this patient. Records may be discussed with other health care providers and/or for educational purposes.

____
Responsible Person

Dr. ______ *Tech* ________