



CROWDER
ORTHODONTICS

WELCOME!

ADULT HEALTH HISTORY

ABOUT YOU

TODAY'S DATE: _____

Name: _____ Preferred Name: _____
 Birthdate: _____ Age: _____ Male Female
 Home Address: _____
 How long have you lived at this address? _____
 Home #: _____ Cell #: _____
 Work #: _____ SS#: _____
 E-mail Address: _____
 Marital Status: Married Divorced Separated Widowed Single
 Children/Ages _____
 Other family members seen by Dr. Crowder? _____
 How did you hear about us? _____
 Employer: _____ Occupation: _____
 Employer's Address: _____
 When/where are the best times to reach you? _____

SPOUSE INFORMATION

Name: _____ DOB: _____ SS# _____
 Work #: _____ Cell #: _____ E-mail: _____
 Employer: _____ Occupation: _____

EMERGENCY INFORMATION

In the event of an emergency, is there a friend or relative that we could contact?
 Name: _____ Relationship: _____
 Home #: _____ Work #: _____ Cell #: _____

DENTAL HISTORY Do you like your smile? Yes No

Previous/present Dentist: _____ Date of last visit: _____

What are the main concerns that you would like orthodontics to address? _____
 Have you ever been evaluated for orthodontic treatment? Yes No
 By whom? _____ When? _____

Your current dental health is: Good Fair Poor
 Do you require antibiotics before dental work? Yes No
 Have you ever had a serious/difficult problem associated with any previous dental work? Yes No

Do you have any of the following habits:
 Lip Sucking/Biting Nail Biting Thumb/Finger Sucking Tongue Thrust Clench/Grind Teeth

Do you generally breath through your mouth? Yes No If yes: While Awake While Asleep

Do you have any missing/extra permanent teeth? _____

Do you have any speech problems? _____

Do your gums bleed? Yes No

Do you still have any wisdom teeth? Yes No

Have you ever had an injury to your: Mouth Teeth Chin

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Yes No

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

MEDICAL HISTORY

Physician's Name _____

Last Visit: _____ Phone #: _____

Your current physical health is: Good Fair Poor

Are you currently being treated for anything specific? Yes No

Please explain: _____

Are you taking any prescription/over-the-counter drugs? Yes No

Please list each one: _____

Do you smoke or use tobacco of any form? Yes No

For Woman: Are you pregnant? Yes No Week #: _____

Have you ever had/experienced any of the following?

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Cancer/Chemotherapy | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> HIV+ | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Heart Surgery/Pacemaker | <input type="checkbox"/> Severe Headaches |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial | (awake/sleep) | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Tuberculosis |
| bones/joints/valves | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Ulcers/Colitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy/Fainting | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Other |
| <input type="checkbox"/> Biophosphanates | <input type="checkbox"/> Fever Blisters/Herpes | <input type="checkbox"/> Mitral Valve Prolapse | |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Psychiatric Problems | |

Please list any serious medical condition(s) not listed above: _____

Please list any drugs/materials that you are allergic to: _____

INSURANCE COVERAGE

Primary Insurance: Dental Coverage? Yes No Orthodontic Coverage? Yes No Medical Coverage? Yes No

Insurance Co. Name: _____ Phone #: _____ Insured's Birthdate: _____

Social Security #: _____ Insurance Co. Address: _____

Insured's Name: _____ Relationship: _____ Group (Plan/Local/Policy) #: _____

Insured's Employer: _____ Employer's Address: _____

Secondary Insurance: Dental Coverage? Yes No Orthodontic Coverage? Yes No Medical Coverage? Yes No

Insurance Co. Name: _____ Phone #: _____ Insured's Birthdate: _____

Social Security #: _____ Insurance Co. Address: _____

Insured's Name: _____ Relationship: _____ Group (Plan/Local/Policy) #: _____

Insured's Employer: _____ Employer's Address: _____

Thank you for filling out this form completely.

I affirm that the information I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services that I may need.

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 the office, use the services of one or more credit reporting services.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductions that my insurance does not cover.

Signature: _____ Date: _____

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