CROWDER
ORTHODONTICS

WELCOME!

ADULT HEALTH HISTORY

ABOUT YOU

TODAY'S DATE: _____

Name:_____ Preferred Name: _____
Birthdate:_____ Age:_____ ☐Male ☐Female
Home Address:_____ City:_____ State:_____ Zip:_____
How long have you lived at this address?: _____
Home#:_____ Cell #_____
Work#:_____ SS #_____
Email 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 #_____ Email: _____
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 breathe 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: ☐Good ☐Fair ☐Poor
Are you currently being treated for anything specific? ☐Yes ☐No
Please expla
in:_____
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 Women: Are you pregnant? ☐Yes ☐No Week #:_____
Have you ever had/experienced any of the following:

☐Abnormal Bleeding
☐HIV +
☐Anemia
☐Arthritis
☐Artificial bones/joints/valves
☐ Asthma
☐ Autism
☐Biophosphanates
☐Blood Tranfusion
☐Cancer/Chemotherapy
☐Congenital Heart Defect
☐Diabetes
☐Difficulty Breathing (awake/asleep)
☐Drug/Alcohol Abuse
☐Epilepsy/Fainting
☐ Fever Blisters/Herpes
☐Heart Attack
☐Heart Murmur
☐Heart Surgery/Pacemaker
☐Hemophelia
☐ Hepatitis
☐High/Low Blood Pressure
☐ Hospitalization
☐ Kidney Problems
☐Mitral Valve Prolapse
☐ Psychiatric Problems
☐ Rheumatic Fever
☐ Severe Headaches
☐Sinus Problems
☐Stroke
☐ Tuberculosis
☐ Ulcers/Colitis
☐ Other

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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