WELCOME TO MARCY ORTHODONTICS

(All information will be kept in strict confidence)

Adult Acquaintance and Medical History Form

PATIENT INFORMATION

Name: _____ Gender: M/F D.O.B: _____ /____ /____
Last First Initial YYYY/ MM / DD

Address: _____ Home Phone: _____
Street City Postal Code

Work Phone: _____ Cell Phone: _____ Email: _____

Employer: _____ Occupation: _____

Marital Status: _____

Medical History

Family Physician: _____ Phone: _____

Yes	No	
☐	☐	Are you under a physician's care at present? Describe: _____
☐	☐	Are you being treated for any medical conditions? Describe: _____
☐	☐	Are you currently taking any prescription or non-prescription medications? _____
☐	☐	Are you allergic to any medications (e.g. Penicillin, sulfa drugs, pain relievers)? Or Latex?_____
☐	☐	Have you ever had any serious illness? Describe: _____
☐	☐	Have you ever been hospitalized or undergone any type of surgery? Describe: _____
☐	☐	Have you ever had prolonged bleeding following a tooth extraction or minor injury? _____
☐	☐	Are there any conditions or diseases that run in your family (e.g. diabetes, heart disease, cancer)? _____
☐	☐	Do you smoke or use any other tobacco products? If yes, how much? _____
☐	☐	For females: are you pregnant, or suspect that you might be? Anticipated due date: _____

Do you have or have you ever had any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Rheumatic Fever	☐	☐	Kidney Disease	☐	☐	Persistent Headaches/Migraines
☐	☐	Heart Murmur	☐	☐	Thyroid Disease	☐	☐	Nerve or Brain Disease
☐	☐	Heart Valve Disease	☐	☐	Liver Disease	☐	☐	Seizures/ Epilepsy
☐	☐	Heart Attack / Stroke	☐	☐	Asthma	☐	☐	Autism
☐	☐	Prosthetic Joint / Valve	☐	☐	Tuberculosis (TB)	☐	☐	Arthritis
☐	☐	High/ Low Blood Pressure	☐	☐	Cancer/ Radiation therapy	☐	☐	Bone Disorders
☐	☐	Hemophilia	☐	☐	Lung Disease	☐	☐	Neck Pain
☐	☐	Blood Disorder	☐	☐	Diabetes	☐	☐	Vision or Hearing Problems
☐	☐	Infectious Disease	☐	☐	Stomach Ulcers	☐	☐	Sleep Apnea
☐	☐	HIV/ AIDS	☐	☐	Herpes (any type)	☐	☐	Sinus Problems
☐	☐	Hepatitis	☐	☐	Skin disease (e.g. Eczema)	☐	☐	Allergies
☐	☐	Mental Health Problems				☐	☐	Other _____

Please list any other significant information about your medical history: _____

_____

_____

Dental History

What is your primary concern about your teeth and smile? _____

_____

Family Dentist: _____ Date of last check up: _____

Yes	No	
☐	☐	Are you currently experiencing any dental pain? _____
☐	☐	Have you had any permanent teeth removed, including wisdom teeth? How many? _____
☐	☐	Have you ever had previous orthodontic treatment or exam? If yes, when? _____ Doctor? _____
☐	☐	Have you ever injured your face, teeth, or mouth? Describe: _____
☐	☐	Do you, or have you, experienced soreness, tightness or pain in the muscles around the jaws and face?
☐	☐	Do you, or have you, experienced pain in your jaw joints? If yes, when? _____
☐	☐	Do you, or have you, experienced difficulty in opening or closing your jaws?
☐	☐	Have your jaws ever been "locked" open or closed?
☐	☐	Do you clench or grind your teeth? If yes, do you where a nightguard? Y/N
☐	☐	Do you find that you breathe predominantly through your mouth, or with your mouth open?

Any other information you can give us is definitely appreciated. The more we know about each person, the more help we can give in managing the orthodontic treatment, both at home and in the office.

_____

_____

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to my clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

_____ _____

Signature of Patient Date

Whom may we thank for referring you to our office: _____

Insurance Information:

Our office bills the Patient or Responsible Party directly for all services rendered. We will complete the necessary forms for your submission to receive the amount of orthodontic coverage to which you are entitled.

Do you have orthodontic coverage?

☐ Yes ☐ No ☐ Dual ☐ Unsure

1. Subscribers Name: _____
   Insurance Company: _____
   Employer: _____
   Policy/Contract #: _____
   I.D./Certificate #: _____

2. Subscribers Name: _____
   Insurance Company: _____
   Employer: _____
   Policy/Contract #: _____
   I.D./Certificate #: _____