Adult Health History Form

RANKIN & FIUME orthodontics
Creating smiles for a lifetime
608 McCarthy Blvd. • New Bern, NC 28562

1. About You

Today's Date: ____/____/_____

Name: _____

I prefer to be called: _____

Home Address: _____

_____

Email Address:

Birth date: ____/____/_____ Age: _____

SS#:_____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home#:_____ Cell#:_____

Work#:_____ Ext.: _____

Employer: _____

Occupation: _____

Where and when are the best times to reach you?
☐ Phone ☐ Email ☐ Text ☐ Mail

Other family members treated by us?

Children (list name and age):

Whom may we thank for referring you?

2. Spouse Information

His/Her Name: _____

Employer: _____

Occupation: _____

Work #: _____ _____

SS#: _____

Birth date: _____/_____/_____

3. Dentist Information

Dentist Name: _____

We recommend that you have seen your dentist within the past year prior to starting orthodontic treatment

Last Dental Exam: _____

4. Orthodontic Insurance

Primary

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

ID #: _____

Insured Name: _____

Relation: _____

Insured's Birth date: _____ / _____ / _____

Insured's Employer: _____

Secondary

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

ID #: _____

Insured Name: _____

Relation: _____

Insured's Birth date: _____ / _____ / _____

Insured's Employer: _____

5. Emergency Contact

His/Her Name: _____

Relationship:_____

Work/Cell#: _____

Home#: _____

6. Medical History

Physician's Name: _____

Phone #: _____ Date of last visit: _____

List any prescription medication you currently take?

For Women:

Are you pregnant? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

	Yes	No
Abnormal bleeding	☐	☐
Diabetes	☐	☐
Lung Disorder	☐	☐
Anemia	☐	☐
Epilepsy	☐	☐
Rheumatic Fever	☐	☐
Tuberculosis	☐	☐
HIV/Aids	☐	☐
Bone disorders	☐	☐
Kidney problems	☐	☐
Nervous disorders	☐	☐
Neural Disorder	☐	☐
Serious injury	☐	☐
Tumor or Cancer	☐	☐ Type:_____
Ear/Throat issues	☐	☐
Hepatitis/Liver	☐	☐
Nasal/Sinus	☐	☐
High Blood Pressure	☐	☐
Radiation/Chemotherapy	☐	☐
Asthma/Hay Fever	☐	☐
Gastrointestinal Disorder	☐	☐
Endocrine Disorder	☐	☐
Arthritis	☐	☐
Congenital Heart Defect	☐	☐
Heart Murmur	☐	☐
Heart Problems	☐	☐

Are there any medical conditions we have not discussed that you feel we should be aware of?

Do you normally require antibiotic pre-medication for dental procedures? ☐ ☐

Are you allergic to any of the following?

	Yes	No
Aspirin	☐	☐
Codeine	☐	☐
Latex	☐	☐
Erythromycin	☐	☐
Nickel	☐	☐
Penicillin	☐	☐

List Other Allergies:

_____

_____

_____

_____

7. Dental History

Chief complaint/reason for visit today:

Have you ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

Have you ever had any pain/tenderness in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Have you ever had an injury to your mouth? ☐ Yes ☐ No

Do you have any missing permanent teeth? ☐ Yes ☐ No

Have you ever had a thumb/finger habit? ☐ Yes ☐ No

☐ Present

☐ Previous

Do you generally breathe through your mouth? ☐ Yes ☐ No

8. Consent

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.
I have received notice of privacy practices. I hereby consent to the making of any necessary diagnostic records, including xrays, to aid in the proper diagnosis and treatment plan.

Signature of Patient **Date**

Click to Submit