Salem Smiles
ORTHODONTICS

Sarah C. Shoaf, DDS, MEd, MS, PC

CONFIDENTIAL MEDICAL/DENTAL HISTORY FORM - ADULT

PATIENT INFORMATION

Patient's name ______________________________ (First, Middle, Last) Preferred Name ____________________

Patient's address ______________________________ (Street, City, State, Zip)

Home phone # ________________ Cell phone # ________________ Work phone # ________________ (Circle best #)

Email address: ______________________________ DOB _____/_____/_____ Sex: M F

Emergency Contact ____________________ Phone # ______________ Relationship to you ____________________

Who referred you to our office? ______________________________

What concerns you most about your teeth? ______________________________

Name of Dentist ____________________ Date last seen ______________ Reason ____________________

Name of Physician ____________________ Date last seen ______________ Reason ____________________

RESPONSIBLE PARTY INFORMATION

Responsible Party 1 ______________________________ Relationship to Patient ______________________________

Home address ______________________________ Home Phone # ____________________

Responsible Party 2 ______________________________ Relationship to Patient ______________________________

Home address ______________________________ Home Phone # ____________________

DENTAL HISTORY - now or in the past have you had (please circle):

Yes No Any teeth removed for any reason ?
Yes No Supernumerary (extra) or congenitally missing teeth?
Yes No Chipped or otherwise injured primary (baby) or permanent teeth?
Yes No Teeth sensitive to hot or cold, teeth throb or ache?
Yes No Jaw fractures, cysts or mouth infections?
Yes No "Dead teeth" or root canals treated?
Yes No Periodontal problems, bleeding gums?
Yes No Thumb, finger or sucking habit? Until what age? _______
Yes No History of speech problems?
Yes No Ever had a prior orthodontic examination or treatment?
Date of past treatment______________________________

Yes No Snoring, sleep apnea? PSG test date ______________
Yes No Tooth grinding, jaw clenching, clicking or locking?
Yes No Pain in jaw?
Yes No Difficulty chewing or jaw opening?
Yes No Aware of loose, broken or missing fillings?
Yes No Any teeth irritating cheek, lip, tongue or palate?
Yes No Frequent canker sores or cold sores?
Yes No Any wisdom tooth problems?
Yes No Wisdom teeth removed? Date _______________
Yes No Are you sensitive orself-conscious about your teeth?
Yes No Presently wearing retainer/mouth guard?

Other concerns about your teeth not listed? ______________________________

MEDICAL HISTORY - now or in the past have you had (please circle):

Yes No Birth defects or hereditary problems?
Yes No Rheumatoid or arthritic conditions?
Yes No Kidney problems?
Yes No Cancer, tumor, radiation treatment or chemotherapy?
Yes No Problems of the immune system? AIDS or HIV positive?
Yes No Fainting spells, seizures, epilepsy, or neurological problems?
Yes No Vision, hearing problems other than corrective lenses?
Yes No Excessive bleeding or bleeding disorder?
Yes No Cardiovascular problems such as chest pain, heart attacks, stroke, inborn heart defects, heart murmurs, angina?
Yes No Do you chew or smoke tobacco?

Yes No Bone fractures, any major accidents?
Yes No Endocrine or thyroid problems?
Yes No Diabetes?
Yes No Stomach ulcer, GERD, or frequent heartburn?
Yes No Hepatitis, jaundice or liver problems?
Yes No Mental health disturbance or behavioral problems?
Yes No History of eating disorder (anorexia, bulimia)?
Yes No High or low blood pressure?
Yes No Hayfever, asthma, sinus trouble?
Yes No Tonsil or adenoid conditions?
Yes No Women – are you pregnant?

List allergies to all medications, latex, or metals ____________________

List all medications, herbal supplements, vitamins, or over the counter medications presently taken: ____________________

____

Describe any operations or surgery you have had, including dates: ____________________

____

Dates and reasons for any hospitalizations: ____________________

____

Are there any other medical conditions that we should be aware of? ____________________

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will inform this practice at my next visit. Further more, I consent to an orthodontic examination and treatment as agreed upon by my orthodontist and myself.

Signed: ____________________ Date signed ____________________
(Patient)

Signed: ____________________ Date signed ____________________
(Dental staff member receiving form)

FINANCIAL AGREEMENT

--- We accept assignment of MOST insurance plans. Your insurance is a contract between you, your employer, and the insurance company; our relationship is with you, NOT the insurance company.
--- ALL charges incurred are charged directly to YOU and you are personally responsible for payment. Deductibles and co-payments are due at the time of treatment. We estimate your co-payments according to your policy. WE DO NOT in any way guarantee that your insurance will pay this amount.
--- If the insurance company doesn't pay within a reasonable amount of time, it is required that you pay the balance due.
--- Your insurance card must be presented at every visit. If there is no insurance card then payment (cash, or credit card) is expected at the time of service.
--- I hereby authorize payment directly to Sarah C. Shoaf, DDS, MEd, MS, PC/Salem Smiles the insurance benefits otherwise payable to me, and authorize release of any information required to process insurance claims.
--- If your account is more than 2 months past due your account will be turned over to Interstate Credit Collections.

____________________ ____________________ ____________________
Patient Signature Patient Social Security Number Date

PATIENT/INSURANCE INFORMATION

Self Father Stepfather Mother Stepmother Guardian (circle one)

Name ____________________ SS# ____________________ DOB ____________________

Address (if different from patient) ____________________

Home Phone ____________________ Cell Phone ____________________ Work Phone ____________________

Employer ____________________

List Insurance Coverage

Insurance Company ____________________ Phone Number ____________________

Claims Address ____________________

Group # ____________________ Policy/ID # ____________________

Updated Health History/
Personal Information:

Date: ______	Date: ______	Date: ______	Date: ______	Date: ______	Date: ______
Initials: ______	Initials: ______	Initials: ______	Initials: ______	Initials: ______	Initials: ______