ARIZONA ORTHODONTIC EXCLUSIVELY, PC
Howard L. Henry DDS MSc
www.arizonaorthodonticsexclusively.com
Orthodontics for children and adults

ADULT HEALTH HISTORY FORM

Welcome! Our specialty is creating smiles, and to do this we treat people, not just teeth! We are about your total health and appreciate your time in this health history.

DATE: _____

Patient's Name _____ Birthdate _____ Age _____
Last First Middle □ Male □ Female Height_____ Weight _____
Name you would like to go by _____
Patient's Address _____ Phone _____
City _____ State _____ Zip _____
E-Mail Address (used for appointment reminders/x-ray & photo viewing, kept confidential): _____
Employed by _____ Bus. Address _____ Phone _____
Occupation _____
Soc. Security # _____Driver's License # _____
Sports, Hobbies _____ Musical Instrument Played _____
Patient's Dentist _____Address _____ Phone_____
Who may we thank for referring you to our office?_____
Name and ages of other members in the family_____
Name of other family members treated in our office_____
Is the Patient: □ Single □ Married □ Divorced □ Widowed
Spouse's Name _____ Employer/Occupation _____

PERSON(S) RESPONSIBLE FOR THIS ACCOUNT

Name_____Address_____City_____State_____Zip_____
SS #_____Daytime Phone #_____Evening Phone #_____

Orthodontic Insurance Information

Insured's Name_____
Insurance Name_____Ins. Ph #_____
Employed by _____Group#_____
Birthdate_____Insured's SS#_____

Secondary Insurance Information

Insured's Name_____
Insurance Name_____Ins.Ph #_____
Employed by _____Group #_____
Birthdate_____Insured's SS#_____

In Emergency Notify_____
Name Address City State Zip Phone

Dental History

YES	NO	
		Approximate date of last dental exam_____
□	□	Have you ever sucked your thumb or fingers?_____Until what age?_____
□	□	Have you ever had any severe injuries in the teeth or to the jaw?_____
□	□	Have you ever had any speech therapy? How long?_____
□	□	Have you ever had any abscessed teeth?_____
□	□	Have you ever been informed of missing or extra teeth?_____
□	□	Do you clench or grind your teeth at night? _____
□	□	Do you have pain or clicking during jaw movement? _____
□	□	Are you concerned about the way your teeth look? _____
□	□	Do you want your teeth straightened? _____
□	□	Do you ever experience any sore or bleeding gums? _____
□	□	Have you ever had any treatment for your gums? _____
□	□	Does anyone in your family have a similar dental condition? _____
□	□	Has anyone in the family had orthodontic treatment? _____
□	□	Have you had any previous orthodontic consultation/treatment? _____

Who first noticed a possible orthodontic problem? _____
Chief concern for evaluation and information desired: _____

Have X-rays of the teeth been taken recently? _____When? _____

MEDICAL HISTORY

Physician _____Date of Last Visit_____
Physician's Address _____City_____ State _____ Zip _____Phone #_____
Please circle Yes or No (If Yes, please fill in the details)
Yes No Are you taking any medication? _____
If yes, please list medication: _____
Yes No Are you allergic to any medication? _____
If yes, please list medication: _____
Yes No Are you presently under the care of a physician? If yes, for what reason? _____
Have you ever had any major illness or major surgery? _____
If yes, please explain: _____
_____
Have you ever been hospitalized? _____If yes, for what reason? _____
Have you had your tonsils or adenoids removed? _____ At what age? _____
Do you have any of the following: Asthma □ Allergies□ Hay fever □
Do you suffer from frequent throat infections? _____
Do you breathe mostly through your: Nose□ Mouth □ Both □ Uncertain □

Yes	No		Yes	No		Yes	No	
□	□	Abnormal Bleeding	□	□	Heart Problems	□	□	Sinusitis
□	□	Anemia	□	□	Hepatitis-Type____	□	□	Thyroid Disease
□	□	Arthritis	□	□	Herpes	□	□	Tuberculosis
□	□	Blood Disorders	□	□	High Blood Pressure	□	□	Aids
□	□	Bone/Joint Disorders	□	□	Hyperactive	□	□	HIV+
□	□	Cancer or Tumor	□	□	Kidney Involvement	□	□	Contact Lenses
□	□	Liver Disease	□	□	Diabetes	□	□	Lung/Respiratory
□	□	Dizziness/Fainting	□	□	Nervous Disorders			Disease
□	□	Emotional Problems	□	□	Endocrine Problems	□	□	Other :_____
□	□	Pneumonia	□	□	Epilepsy			_____
□	□	Prolonged Bleeding	□	□	Glaucoma			_____
□	□	Rheumatic Heart	□	□	Heart Murmur			_____
□	□	Rheumatic Heart Disease	□	□	Sleep Apnea			

If yes, what is your sleep index? _____

FOR WOMEN ONLY: Are you pregnant? _____
REMARKS: _____
_____
_____

Benefits of Orthodontics

Aesthetics, Health and Function

Orthodontics is a service that provides an improvement in the appearance of the teeth, and in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime, and there can be some movement of the teeth, and some change after treatment. I hereby state that I have read and understand the above paragraph, and that I have truthfully to the best of my ability answered all the above questions.

Patient/Patient Signature _____ Date _____

The above information is true to the best of my knowledge. I hereby authorize you to release and/or share this information with my general dentist and/or physician. I understand that, where appropriate, credit bureau reports may be obtained.

Date_____ Signature _____