American Association of Orthodontists
My Life. My Smile. My Orthodontist.®

CANALES ORTHODONTICS

Medical Dental History Form
For Adult Patients

PATIENT

Date _____

Last Name _____ First Name _____ Middle Initial _____

Title: Mr. Mrs. Ms. Miss. Dr. Other _____ I prefer to be called _____

Birth Date _____ Sex: Male Female Social Security # _____- _____ - _____

Marital Status: Single Married Separated Divorced Widowed

Home Address _____ City, State, Zip code _____

Home phone (____) _____-_____ Cell phone (____) _____-_____ Work phone (____) _____-_____

E-mail address _____

Please circle your preferred method(s) for receiving appointment reminders: email or text message

If text message, please list your coverage provider (AT&T, Verizon, T-Mobile, etc): _____

FINANCIAL RESPONSIBILITY

Full Name _____ Date of birth:_____ Social Security # _____- _____ - _____

Address (if different from above) _____ City, State, Zip _____

Years at address _____ ☐ Own ☐ Rent Previous address in same local area? Y / N

Home phone (____) _____-_____ Cell phone (____) _____-_____ E-mail address _____

Primary Source of Income:

☐ Employed ☐ Unemployment compensation ☐ Other _____
☐ Retired ☐ None

Occupation (choose the best option):

☐ Professional/Executive ☐ Military - officer ☐ Trade/Technical ☐ Labor
☐ Sales/Administrative ☐ Military - enlisted ☐ Service ☐ None

Employer _____ # Years at Current Employer _____

I give Canales Orthodontics permission to release financial information to the following persons:

_____ _____ _____

CLOSEST RELATIVE

Spouse or closest relative's name(s) _____

Title: Mr. Mrs. Ms. Miss. Dr. Other _____ Relationship to patient _____

Address (if different than patient address) _____

Home phone (____) _____-_____ Cell phone (____) _____-_____ Work phone (____) _____-_____

DENTIST

Dentist Name _____ Address, City, State _____

Last seen _____ Reason _____ Next appointment _____

Other dentists/dental specialists now being seen:

Name _____ City, State _____ Reason _____

PHYSICIAN

Patient's Physician _____ City, State _____ Last seen _____

Reason _____ Date of most recent physical exam _____

Other physicians/health care providers being seen now:

Name _____ City, State _____

Reason _____

GENERAL INFORMATION

What concerns you about your teeth? _____

Who suggested that you might need orthodontic treatment? _____

Why did you select our office? _____

Have you had any previous orthodontic treatment? Please describe _____

Have any other family members been treated in this office? Please name them. _____

Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain. _____

_____

DENTAL INSURANCE

Primary policy holder's full name _____ Birthdate _____

Social Security # _____- _____ - _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID # _____

Does this policy have orthodontic benefits? Yes No Don't know

Secondary policy holder's full name _____ Birthdate _____

Social Security #_____- _____ - _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group #_____ ID # _____

Does this policy have orthodontic benefits? Yes No Don't know

MEDICAL INSURANCE

Policy holder's full name _____

Insurance company _____

Your answers are for office records only, and are confidential. A thorough medial history is essential to a complete orthodontic evaluation. For the following questions mark yes, no, or don't know/understand (dk/u).

MEDICAL HISTORY

Now or in the past, have you had:

yes no dk/u Birth defects or hereditary problems?
yes no dk/u Bone fractures, or major injuries?
yes no dk/u Any injuries to face, head, neck?
yes no dk/u Arthritis or joint problems?
yes no dk/u Endocrine or thyroid problems?
yes no dk/u Diabetes or low sugar?
yes no dk/u Kidney problems?
yes no dk/u Cancer, tumor, radiation treatment or chemotherapy?
yes no dk/u Stomach ulcer, hyperacidity, acid reflux?
yes no dk/u Immune system problems?
yes no dk/u History of osteoporosis?
yes no dk/u Gonorrhea, syphilis, herpes, sexually transmitted diseases?
yes no dk/u AIDS or HIV positive?
yes no dk/u Hepatitis, jaundice or other liver problem?
yes no dk/u Polio, mononucleosis, tuberculosis, pneumonia?
yes no dk/u Seizures, fainting spells, neurologic problem?
yes no dk/u Mental health disturbance or depression?
yes no dk/u Vision, hearing, or speech problems?
yes no dk/u History of eating disorder (anorexia, bulimia)?
yes no dk/u High or low blood pressure?
yes no dk/u Excessive bleeding or bruising, anemia?
yes no dk/u Chest pain, shortness of breath, tire easily, swollen ankles?
yes no dk/u Heart defects, heart murmur, rheumatic heart disease?
yes no dk/u Angina, arteriosclerosis, stroke or heart attack?
yes no dk/u Skin disorder (other than common acne)?
yes no dk/u Do you eat a well-balanced diet?
yes no dk/u Frequent headaches or migraines?
yes no dk/u Frequent ear infections, colds, throat infections?
yes no dk/u Asthma, sinus problems, hayfever?
yes no dk/u Tonsil or adenoid condition?
yes no dk/u Do you frequently breathe through your mouth?

Have you had allergies or reactions to any of the following:

yes no dk/u Local anesthetics (novocaine, lidocaine, xylocaine)
yes no dk/u Latex (gloves, balloons)
yes no dk/u Aspirin
yes no dk/u Ibuprofen (Motrin, Advil)
yes no dk/u Penicillin
yes no dk/u Other antibiotics
yes no dk/u Metals (jewelry, clothing snaps)
yes no dk/u Acrylics
yes no dk/u Plant pollens
yes no dk/u Animals
yes no dk/u Foods
yes no dk/u Other substances _____

DENTAL HISTORY

Now or in the past, have you had:

yes no dk/u Permanent or extra (supernumerary) teeth removed?
yes no dk/u Supernumerary (extra) or congenitally missing teeth?
yes no dk/u Chipped or injured primary or permanent teeth?
yes no dk/u Any sensitive or sore teeth?
yes no dk/u Bleeding gums, bad taste or mouth odor?
yes no dk/u Jaw fractures, cysts, infections?
yes no dk/u Any teeth treated with root canals or pulpotomies?
yes no dk/u "Gum boils," frequent canker sores or cold sores?
yes no dk/u History of speech problems or speech therapy?
yes no dk/u Difficulty breathing through nose?
yes no dk/u Food impaction between the teeth?
yes no dk/u Mouth breathing habit or snoring at night?
yes no dk/u History of speech problems?
yes no dk/u Frequent oral habits (sucking finger, chewing pen, etc.)?
yes no dk/u Teeth causing irritation to lip, cheek or gums?
yes no dk/u Abnormal swallowing (tongue thrust)?
yes no dk/u Tooth grinding or clenching?
yes no dk/ u Clicking, locking in jaw joints?
yes no dk/u Soreness in jaw muscles or face muscles?
yes no dk/u Ringing in ears, difficulty in chewing or opening jaw?
yes no dk/u Have you ever been treated for "TMJ" or "TMD" problems?
yes no dk/u Any broken or missing fillings?
yes no dk/u Any serious trouble associate with previous dental treatment?
yes no dk/ u Have you ever been diagnosed with gum disease or pyorrhea?
yes no dk/u Have you ever had an orthodontic consultation or treatment before now?

PATIENT HEALTH INFORMATION

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you take.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Have you ever taken any medications to strengthen your bones? Please describe. _____

_____

Do you take antibiotic pre-medication before any dental procedures? Yes No

Do you or have you ever had a substance abuse problem? _____ Do you chew or smoke tobacco? _____

Have you noticed any changes in your face or jaws? _____ Any other physical problems? _____

How often do you brush? _____ How often do you floss?_____

Women: Are you pregnant? Yes No Are you trying to become pregnant? Yes No

FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following health problems? If so, please explain. _____

_____

Bleeding disorders _____ Diabetes _____

Arthritis _____

Severe allergies _____

Unusual dental problems _____

Jaw size imbalance _____

Other family medical conditions? _____

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

I have read the above questions and understand them. 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. I will notify my orthodontist of any changes in my medical or dental health.

I understand that this office reserves the right to verify the credit status of potential patients and/or those responsible for payment prior to extending credit for treatment fees and may use one or more credit reporting services.

Signature _____

Date_____

CANALES ORTHODONTICS, LLC

ACKNOWLEDGEMENT OF RECEIPT OF HIPPA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of this office's HIPPA Notice of Privacy Practices.

_____
Patient Name (please print)

_____ _____
Patient Signature Date

OR

_____ _____
Signature of Personal Representative Date

Authority of Personal Representative to Sign for Patient (Check One):

_____Parent _____Guardian _____Power of Attorney _____Other:_____

****Please Note: It is your right to refuse to sign this Acknowledgement****

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____ _____
Signature of Staff Member Date