Medical Dental History Form
for Adult Patients

PATIENT

Date ____________________

Patient's 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 ____

Occupation Employer ____

CLOSEST RELATIVE

Spouse or closest relatives 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 and 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 ____ Next appointment _________

Most recent physical exam ________________________________

Other physicians/health care providers being seen now:

Name____ City _____________________State____

Reason ____

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.

____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? ____

Address (if different from page 1)________________________________ City _____________State _____

Zip ______________

Home phone ________________________Cell phone _____________________

E-mail address(es) _________________________

Social Security # ________________________________ Employer:______________________________________

Who will be responsible for bringing the patient to orthodontic appointments? ______________________________

DENTAL INSURANCE

Insurance Company ____

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 ____

kwongorthodontics

specializing in orthodontics for children & adults

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, STD?
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, swollen ankles?
yes _no_ dk/u_ Heart defects, heart murmur, rheumatic 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 teeth removed?
yes _no_ dk/u_ 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 or cold sores?
yes _no_ dk/u_ 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 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? ____

Women: Are you 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.

Signature ____

Date_____________________________

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.

Signature ____

Date_____________________________

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices. Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

Please sign this form below under the heading "acknowledgement" to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

List Patient Names (Print)

____.　　____.

Parent/Guardian Signature　　____.

____.

____.

Date:_______________.

For office use only Patient refused to sign The following circumstances prohibited the patient from signing the Acknowledgement:
An emergency situation prevented the patient from signing the Acknowledgement. ____. Office Personnel (signature)　　Office Personnel (Print name) Date:____________________________________.

Patient Consent

Please sign this form below under the heading "consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

List Patient(s) Name (print)

____.　　____.

Parent/Guardian Signature　　____.

____.

Date:________________.　　____.

Kwong Orthodontics, PC 5907 Oakland Drive, Portage MI 49024 (269) 327-4459 O (269) 327-3019 F