Please respond to all questions

Adult Health History

Drs. Geyer & Binzer, PC

Specialists in Orthodontics

PATIENT'S NAME______________________ Prefers to be called "________________" Male ❑ Female ❑

Whom may we thank for referring you to our office?______________________ General Dentist______________________

Where & When are the best times to reach you? ______________________

Other family members (please list names & ages) ______________________

Has anyone in the family had braces?__________Who?______________ Were you/they pleased with the results?__________

How often do you see the dentist?______________________ Date of last dental exam (Mo./Yr.)______________

What are the main concerns that you would like orthodontics to address?______________________

____

How do you feel about the possibility of wearing orthodontic appliances? ______________________

Have you been evaluated for or had orthodontic treatment before?	Y	N
Are you self-conscious of your teeth?	Y	N
Have there been any injuries to your face, mouth, teeth or chin?	Y	N
Have you ever been informed of any missing or extra permanent teeth?	Y	N
Have you ever had any pain/discomfort in your jaw joint (TMJ)?	Y	N
Do you have any dental problems at this time (pain, cavities, etc.)?	Y	N
Are you apprehensive about receiving dental care?	Y	N

Have you ever had any of the following **habits**?

Thumb/finger sucking	Y	N	Speech problems	Y	N
Mouth breathing	Y	N	Finger nail biting	Y	N
Clenching/grinding teeth	Y	N	Tongue thrust	Y	N
Smoking	Y	N			

Are you **allergic** to any of the following?

Penicillin	Y	N	Nickel	Y	N
Latex	Y	N	Any other medication	Y	N

Other allergies:______________________

If any of your answers are 'Y', what happens when you are exposed to the allergen?______________________

MEDICAL HISTORY:

Current Physician:______________________

Any health problem	Y	N	Ulcers	Y	N
Any hospitilizations	Y	N	Severe headaches	Y	N
Taking any medications	Y	N	Pain of head/face	Y	N
Please list them______________			Diabetes	Y	N
Forceps used during your birth	Y	N	Psychiatric counseling	Y	N
Rheumatic fever, heart disease			Blood transfusions	Y	N
heart murmur	Y	N	Hepatitis	Y	N
Latex Sensitivity	Y	N	Tuberculosis	Y	N
Asthma/respiratory problems	Y	N	AIDS/HIV virus	Y	N
Prolonged bleeding or anemia	Y	N	Mouth/lip lesions (sores)	Y	N
Thyroid or hormone therapy	Y	N	Periodontal Disease	Y	N
Recurrent or chronic illness	Y	N	Epilepsy/seizures	Y	N
			Other infections	Y	N

Please explain any "Y" answers above______________________

____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my child's medical status.

______________________ Signature

______________________ Date

(OVER)

For Office Use Only

TMD HX - WNL CL/POP O-LOCK C-LOCK R L OTHER______________ REC TFR POL EXP__________

DISC.______________________

A B C

Patient Information

Date____________________

Patient's Name____
Last First Middle

Address____
Street City State Zip

Home Phone________________ Birthdate________________ Social Security #________________

Responsible Party Information

Name________________________________ ____________ ________________
Last First Middle Marital Status E-Mail Address

Residence____
Street City State Zip

Mailing Address____
Street City State Zip

How long at this address? ________________________

Home Phone________________ Work Phone________________ Cell Phone ________________

Previous Address (if less than 3 years)____
Street City State Zip

Social Security #________________ Birthdate________________ Relationship to Patient________________

Employer________________ Occupation________________ No. Years Employed__________

Spouses Name________________________________ Relationship to Patient________________

Employer________________ Occupation________________ No. Years Employed__________

Social Security #________________ Birthdate________________ Work Phone________________

Orthodontic Insurance Information

Policy Holder's Name________________________ Soc. Sec. or Alternate ID #________________

Insurance Company________________ Group No.__________ Policy Holder's B-day__________

Insurance Co. Address____

Policy Holder's Employer____

Do you have dual coverage? Yes ❑ No ❑ If yes: Insurance Phone #________________

Policy Holder's Name________________________ Soc. Sec. or Alternate ID #________________

Insurance Company________________ Group No.__________ Policy Holder's B-day__________

Insurance Co. Address____

Policy Holder's Employer________________________ Insurance Phone #________________

Emergency Information

Name of nearest relative not living with you____

Complete address____

Home Phone________________ Work Phone________________ Cell Phone ________________

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parents signature if minor)____

Updates (date & initial)____________ ____________ ____________ ____________

CONFIDENTIAL (for record and pretreatment evaluation)