REBECCA H. HOHL DDS • MS
ORTHODONTIST

Confidential Adult Patient Health History & Information

Date: _____

Patient Information

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Nickname _____ Birthdate_____ Age _____ Sex_____ Social Security # _____

Marital Status: Single_____ Married_____ Widowed_____ Divorced_____

Employer_____ Occupation _____

Home Phone _____ Work Phone _____ Mobile Phone_____

Spouse's Name_____
Last First Middle

Spouse's Birthdate_____Spouse's Employer_____ Spouse's Cell Phone_____

Phone number we should use to confirm appointments _____
Text numbers we should use to confirm appointments _____
Email address we can use for appointment reminders _____
Who may we thank for referring you to our office?_____
Hobbies/interests_____

Responsible Party Information

Name of person financially responsible for account _____
Social Security # _____ Birthdate _____ Relationship to Patient _____
Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Mobile Phone_____
Employer _____ Occupation_____
Correspondence should be sent to: Patient's address_____ Financially Responsible address_____

Insurance Information

*Primary Dental Insurance Company & Address*_____

Subscriber's Name_____ Subscriber's Social Security Number_____
Relationship to Patient_____
Subscriber's Address_____

Subscriber's Date of Birth_____ Subscriber's Employer_____

Subscriber's ID_____ Group #_____

*Secondary Dental Insurance Company & Address*_____

Subscriber's Name_____ Subscriber's Social Security Number_____

Relationship to Patient_____

Subscriber's Address_____

Subscriber's Date of Birth_____ Subscriber's Employer _____

Subscriber's ID_____ Group #_____

Dental History

What is the main orthodontic problem as you see it? _____

_____

Are you sensitive about the appearance of your teeth?_____

Are you sensitive about the appearance of any facial features? (nose, chin, lips, etc.)_____

What do you consider the main benefits of orthodontic treatment?

Cosmetic_____ Functional_____ Psychological/Emotional_____ Other _____

How do you feel about wearing braces? _____

Have you ever had an orthodontic consultation? _____

Have you ever had braces before? _____ If Yes, when _____

Has anyone in the family received orthodontic treatment? _____ If yes, who? _____

What would you like orthodontic treatment to accomplish? _____

Are you interested in: Clear braces_____ Invisalign®_____

Name of your general dentist: _____

Frequency of dental checkups: once/year_____ twice/year_____ Date of last dental exam _____

Answer yes or no if applicable now or in the past:

Y N Apprehensive about dental care	Y N Jaw joint sounds	Y N Difficulty chewing or opening jaw
Y N Brush teeth daily	Y N Jaw joint pain	Y N Cysts or mouth infections
Y N Floss teeth daily	Y N Jaw "tires" when eating	Y N Frequent clenching of teeth
Y N Fluoride treatments	Y N Jaw catches when opening	Y N Injury to either jaw
Y N Previous orthodontic therapy	Y N Jaw locks in closed position	Y N Injury involving teeth
Y N Frequent canker sores	Y N Jaw locks in open position	Y N Grinding of teeth
Y N Thumb/finger sucking habit	Y N Jaw pain or ringing in the ears	Y N Had periodontal treatment
Y N Frequently chews gum	Y N Wake up with sore teeth	Y N Speech therapy
Y N Discomfort from teeth or gums	Y N Wake up with sore jaw	Y N Body piercing
Y N Bleeding gums	Y N Snores when sleeping	Y N Gag reflux
Y N Teeth that are shifting	Y N Mouth breathing	Y N Any missing permanent teeth
Y N Any injuries to face, mouth, teeth	Y N Sleeps with mouth open	Y N Oral Surgery

Other_____

If you answered **yes** to any of the above, please explain_____

_____

_____

Medical History

Patient's Physician _____ Approximate date of last exam_____

Are currently seeing a Physical Therapist or Chiropractor? _____, If yes Name & Address_____

Are you currently in good physical health? Yes_____ No_____ briefly explain, if no_____

Please list any medication's you are currently taking_____

_____

_____

List any drug allergies or sensitivities you may have_____

_____

Answer yes or no if applicable now or in the past:

Y N Allergies (latex-gloves/balloons)	Y N Anemia	Y N Hormone therapy	Y N Emotional problems
Y N Allergies (metals-jewelry/clothing)	Y N HIV/AIDS	Y N Diabetes	Y N Psychological counseling
Y N Allergies (acrylic)	Y N Radiation treatment	Y N Hepatitis	Y N Handicap/disabilties
Y N Allergies (medication)	Y N Cancer	Y N Rheumatic fever	Y N Requires premedication
Y N Allergies (food)	Y N Family history of cancer	Y N Tuberculosis	Y N Ever been hospitalized
Y N Allergies (seasonal)	Y N Bone disorder/bone loss	Y N Heart disease	Y N Tobacco use
Y N Enlarged tonsils	Y N Immunodeficiency	Y N Liver disease	Y N Bottle-fed
Y N Tonsils/Adenoids removed	Y N Endocrine problems	Y N Kidney disease	Y N Breastfed
Y N Frequent sore throats	Y N Heart murmur	Y N Lung disease	Y N Born premature___weeks
Y N Cleft palate/lip	Y N Heart attack/stroke	Y N Pneumonia	Y N Hemophilia
Y N Asthma	Y N Congenital heart defect	Y N Arthritis	Y N Are you pregnant (females)
Y N Facial pain	Y N Frequent headaches	Y N Tongue thrust	Y N Back or neck injuries
Y N Back, neck or shoulder pain	Y N Frequent nausea	Y N Dizziness	Y N Balance issue
Y N Scoliosis	Y N Growth problems	Y N Ear pressure	Y N Foot/ankle sprain
Y N Knee, hip, foot pain	Y N ADHD	Y N Autism	Y N Nervous disorder/anxiety
Y N Intermittent blurred vision	Y N Tone/ringing in ears	Y N Torticollis	Y N Loss of place when reading
Y N Hypersensitivity (light, sound, movement)	Y N Difficulty with compre-hension or mental fog	Y N Hypertension/high blood pressure	Y N Frequent or large changes in vision prescription

Right or left handed_____ Other_____

If you answered **yes** to any of the above, please explain_____

_____

_____

I understand that the information 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 it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature of Patient Date