



ADULT FORM

WELCOME to Quimby and Collins Orthodontics! We are pleased that you contacted our office for an orthodontic evaluation. Please complete the questionnaire and bring it with you to your appointment.

Patient's Name: Last First MI Gender Birth Date Age SSN Address City State Zip Home Phone Work Phone Employer Position Employer Address City State Zip

Email address for reminder emails:

If your insurance pays the provider directly we will gladly submit the insurance for you. All requested information must be completed in order to submit to your insurance. Please bring verification of your insurance to your consultation. If your insurance pays the subscriber, we will provide you with the insurance claim forms for your submission. We will not accept this insurance.

SUBSCRIBER'S NAME Relationship to patient SSN Date of Birth Marital Status Address City State Zip Home Phone Work Phone Employer Position Employer Address City State Zip Dental Insurance Co. Phone Group # ID#

Health History Questionnaire

Family physician name Date of your last visit to this physician Date of last complete physical exam Examining doctor's name What is your approximate height? ft in. What is your approximate weight? lbs. Do you smoke or use any tobacco products? Do you use any non-prescription drugs? Have you ever taken the drug Phen-fen and or Redux?

Table with 6 columns: History Of Problems, YES, NO, History of Problems, Yes, NO. Rows include Nose/Sinus, Asthma, Breathing Disorder, Heart Murmur, High Blood Pressure, Rheumatic Fever, Endocrine, Chronic Disease, Panic Disorders, Cancer, Tuberculosis, Hepatitis, HIVpositive/AIDS, Surgeries, Epilepsy, Kidney Disease, Diabetes/Blood Sugar, Blood Disorders, Allergic Reactions, Thyroid Problems, Radiation Therapy.

If YES is checked, please list the specific problem(s):

Please list current medications:

Blank lines for listing specific problems and current medications.

**Females:**

Are you pregnant now or do you think you may be? \_\_\_ Do you anticipate becoming pregnant? \_\_\_\_\_

**Dental History:**

Name of your family dentist: \_\_\_\_\_ Date of your last visit: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**Today's chief concern:** \_\_\_\_\_

| <b>History of:</b> | <b>YES</b>               | <b>NO</b>                |   |
|--------------------|--------------------------|--------------------------|---|
| Tooth injury       | <input type="checkbox"/> | <input type="checkbox"/> | Chipped ___ Broken___ Lost___   |
| Jaw injury         | <input type="checkbox"/> | <input type="checkbox"/> | Age ___   |
| Bleeding gums      | <input type="checkbox"/> | <input type="checkbox"/> | Usually ___ Sometimes ___ Rarely ___<br>When: ___Brushing ___Flossing ___Eating   |
| Oral disease       | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers ___ Sores___ Cancer ___  |
| Grinding teeth     | <input type="checkbox"/> | <input type="checkbox"/> | During the day ___ During the night___  |
| Clenching teeth    | <input type="checkbox"/> | <input type="checkbox"/> | During the day ___ During the night___  |
| Oral habits        | <input type="checkbox"/> | <input type="checkbox"/> | Thumb sucking ___ Finger sucking ___<br>Tongue thrusting ___ Nail biting ___  |
| Jaw joint pain     | <input type="checkbox"/> | <input type="checkbox"/> | Right TMJ: ___ Constant ___ Periodic<br>When you: ___ chew ___talk ___ open ___ close<br>Left TMJ: ___ Constant ___ Periodic<br>When you: ___ chew ___talk ___ open ___ close |
| Jaw joint noises   | <input type="checkbox"/> | <input type="checkbox"/> | Right: ___ clicking ___ popping ___ grating ___<br>Left: ___ clicking ___ popping ___ grating ___   |
| Jaw joint locking  | <input type="checkbox"/> | <input type="checkbox"/> | Right: ___ when open ___ when closed ___<br>Left: ___ when open ___ when closed ___   |

| <b>Have you had:</b>     | <b>Yes</b>               | <b>NO</b>                | <b>Explain Treatment</b> | <b>Date</b> | <b>Doctor</b> |
|--------------------------|--------------------------|--------------------------|--------------------------|-------------|---------------|
| Periodontal treatment?   | <input type="checkbox"/> | <input type="checkbox"/> | _____                    | _____       | _____         |
| Orthodontic treatment?   | <input type="checkbox"/> | <input type="checkbox"/> | _____                    | _____       | _____         |
| Endodontic treatment?    | <input type="checkbox"/> | <input type="checkbox"/> | _____                    | _____       | _____         |
| Oral Surgery?            | <input type="checkbox"/> | <input type="checkbox"/> | _____                    | _____       | _____         |
| Prosthodontic treatment? | <input type="checkbox"/> | <input type="checkbox"/> | _____                    | _____       | _____         |

I hereby certify that I have reviewed the above medical and dental history and agree it is, to the best of my knowledge, accurate at this time. If there are any future changes in this information I will inform the practice of these changes.

Signature of person filling out this health history form \_\_\_\_\_ Date \_\_\_\_\_

Signature of doctor who reviewed this form \_\_\_\_\_ Date \_\_\_\_\_