

ADULT FORM

Initial Form Reviewed By:	
Final Review of Form By:	

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.

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SUBSCRIBER'S NA	ME		Relatio	onship to	patient				
SSN			Date of Birth			Marital Stat	us		
Address			City	S	tate	Zip			
Home Phone			Work Phone						
Employer						Position			
Employer Address			City			State Zin			
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			Health History	/ Ones	stion	naire			
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Do you smoke or use a Have you ever taken th			ducts? Do n and or Redux?	you use	any noi	n-prescription drugs?			
History:	YES	NO	History:	YES	NO	History:	YES	NO	
Nose/Sinus			Hepatitis			Operations			
Asthma			HIVpositive/AIDS			Hospitalizations			
Breathing Disorder			Surgeries			Any drug use			
Heart Murmur			Epilepsy			Osteoporosis			
High Blood Pressure			Kidney Disease			Stomach Ulcer			
8			Diabetes/Blood Sugar			Headaches			
Rheumatic Fever			Blood Disorders			Skin Disorder			
Rheumatic Fever			Allergic Reactions			Tonsil/Adenoid Condi	tion		
Rheumatic Fever Endocrine				_	_	Headaches			
Rheumatic Fever Endocrine Chronic Disease Panic Disorders			Thyroid Problems						
Rheumatic Fever Endocrine Chronic Disease Panic Disorders Cancer			Thyroid Problems Radiation Therapy			Tuberculosis			
Rheumatic Fever Endocrine Chronic Disease Panic Disorders Cancer If YES is checked, panecific problem(s)	□ □ □ please l		Thyroid Problems Radiation Therapy			Tuberculosis			

Turn Over



ADULT FORM

Allergies

Please	list	any	known	allergies:
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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: Now or in the past, has the patient had: YES NO	□ Asp	oirin	□ Penio	cillin			□ Ibu	_	☐ Sulfate	□ Metal	□ Foo	
Name of your family dentist:	Females: Are you pregnant now or do you think you may be? Do you anticipate becoming pregnant?											
YES NO □ Permanent or "extra" (supernumerary) teeth removed? □ Supernumerary (extra) or congenitally missing teeth? □ Chipped or otherwise injured primary (baby) or permanent teeth? □ Teeth sensitive to hot/cold; teeth that throb or ache? □ Jaw fractures, cysts or mouth infections? □ Bleeding gums, bad taste or mouth odor Periodontal "gum problems"? □ Gum boils", frequent canker sores or cold sores? □ Ahnormal swallowing habit (tongue thrusting)? □ History of speech problems? □ Mouth breathing habit, snoring or difficulty in breathing? □ Tooth grinding or jaw clenching? □ Tooth grinding or jaw clenching? □ Tooth grinding or jaw clenching? □ Toothodontic treatment? □ Deriodontal treatment? □ Toothodontic treatment? □ Dorthodontic treatment? □ Concerned about spaced, crooked or protruding teeth? □ Aware or concerned about under or over developed jaw? □ Any wisdom tooth problems? □ Had any periodontal (gum) treatment? □ Had any serious trouble associated with any previous dental treatment? □ Ever had a prior orthodontic examination or treatment? □ Ever had a prior orthodontic examination or treatment? □ Would you object to wearing orthodontic appliance (braces) should they be indicated? Have you had: Yes NO Explain Treatment Date Doctor □ Periodontal treatment? □ Concerned about spaced, crooked or protruding teeth? □ Any relative with similar tooth or jaw relationships' cold space jaw? □ Any prelative with similar tooth or jaw relationships' cold space jaw? □ Had any periodontal (gum) treatment? □ Had any serious trouble associated with any previous dental treatment? □ Ever had a prior orthodontic examination or treatment? □ Security of the problems? □ Would you object to wearing orthodontic examination or treatment? □ Concerned about under or over developed jaw? □ Any relative with similar tooth or jaw relationships' cold space jaw? □ Any relative with similar tooth or jaw relationships' cold space jaw? □ Any relative with similar tooth or jaw relationships' cold space jaw? □ Any relative with similar tooth or	Name How o	of your did you l	family d near abou	entist:_ it us? _								
Permanent or "extra" (supernumerary) teeth removed?			past, ha	s the p	patient l	nad:	MEG	NO				
teeth removed? around the ears? Difficulty in chewing or jaw opening? Have you ever been treated for "TMD" or "TMJ" problems? Have you ever been treated for "TMD" or "TMJ" problems? Have you ever been treated for "TMD" or "TMJ" problems? Have you had: Yes NO Explain Treatment Date Doctor Periodontal treatment? Have you had: Yes NO Explain Treatment Date Doctor Periodontic treatment? Chipped or otherwise injured primary (baby) or permanent teeth? Have you ever been treated for "TMD" or "TMJ" problems? Have you had: Yes NO Explain Treatment Date Doctor Doctor Date			mant an "a	tro?? (a		~~~~·)			in on sononoss in th	no muscles of the	faaa am	
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I hereby certify that I have reviewed the above medical and dental history and agree it is, to the bes	here	hy corti	fy that I	hove	rovious	d the abo	ve medical	and den	tal history and	agree it is to	the best o	
knowledge, accurate at this time. If there are any future changes in this information I will inform the pra												
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Date Date_

Signature of person filling out this health history form ______Signature of doctor who reviewed this form _____