RICHMOND ORTHODONTICS

American Association of Orthodontists

CONFIDENTIAL

Medical Dental History Form
For Adult Patients

PATIENT

Date ________________ Last name ____________________________________ First name ________________________________

Title [ ] Mr [ ] Mrs [ ] Ms [ ] Dr [ ] Other _______________ I prefer to be called _________________________________

Birth date ___________________________ Gender [ ] Male [ ] Female Social Security # __________-_________-___________

Home address ____ City, State, Zip ______________________________

Cell phone _______________________ Cell phone provider _____________________ [ ] send text appointment reminder

Email address ____ Home phone ________________________

Employer ____ Occupation ____

EMERGENCY CONTACT

Emergency contact name ____

Relationship to patient _______________________________________ Cell phone ____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? ____

Address ____ Cell phone _______________________

DENTAL INSURANCE

[ ] Check here if the patient does not have dental insurance

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

HIPAA - AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Richmond Orthodontic Specialists is authorized to release information, as indicated, to the following individuals:

Name	Relationship to Patient	Check the Information to Release: Any	Clinical	Financial
___________________________________	__________________	________	________	________
___________________________________	__________________	________	________	________

GENERAL INFORMATION

What concerns you about your teeth? ____

How do you feel about orthodontic treatment? ____

Who referred you to our office? ____

Describe any previous orthodontic treatment or consultations ____

Have any other family members been treated in this office? Please name them. ____

Dentist ____ Other dental specialists ______________________________________

MEDICAL AND DENTAL 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 Cancer, tumor, radiation, chemotherapy?
[ ] yes [ ] no [ ] dk/u Diabetes or low sugar
[ ] yes [ ] no [ ] dk/u History of osteoporosis or bone disorders?
[ ] yes [ ] no [ ] dk/u AIDS or HIV positive?
[ ] yes [ ] no [ ] dk/u Seizures, fainting spells, neurologic problems?
[ ] yes [ ] no [ ] dk/u Mental health disturbances or depression?
[ ] yes [ ] no [ ] dk/u History of eating disorder?
[ ] yes [ ] no [ ] dk/u High or low blood pressure?
[ ] yes [ ] no [ ] dk/u Excessive bleeding, bruising tendency, anemia?
[ ] yes [ ] no [ ] dk/u Heart defects, heart murmur, heart surgery?
[ ] yes [ ] no [ ] dk/u Vision, hearing, speech problems?
[ ] yes [ ] no [ ] dk/u Previous or current use of IV bisphosphonates such as Zometra, Aredia, or Didronel?
[ ] yes [ ] no [ ] dk/u Previous or current use of oral bisphosphonates such as Fosamax, Actonel, Boniva, Skelid, or Didronel?
[ ] yes [ ] no [ ] dk/u Substance abuse problem?
[ ] yes [ ] no [ ] dk/u Tobacco use?

Women: Are you currently pregnant? [ ] Yes [ ] No

Do you have allergies or reactions to any of the following?

[ ] yes [ ] no [ ] dk/u Dental local anesthetics (ex lidocaine)
[ ] yes [ ] no [ ] dk/u Latex
[ ] yes [ ] no [ ] dk/u Metals (jewelry, clothing snaps)
[ ] yes [ ] no [ ] dk/u Medications ___________________________

Now, or in the past, have you had:

[ ] yes [ ] no [ ] dk/u Erupting teeth very early or very late?
[ ] yes [ ] no [ ] dk/u Primary teeth removed that were not loose?
[ ] yes [ ] no [ ] dk/u Permanent or extra teeth removed?
[ ] yes [ ] no [ ] dk/u Supernumerary or congenitally missing teeth?
[ ] yes [ ] no [ ] dk/u Chipped or injured permanent teeth?
[ ] yes [ ] no [ ] dk/u Any sensitive or sore teeth?
[ ] yes [ ] no [ ] dk/u Tooth grinding or clenching?
[ ] yes [ ] no [ ] dk/u History of gum disease
[ ] yes [ ] no [ ] dk/u Jaw fractures, cysts, infections?
[ ] yes [ ] no [ ] dk/u Teeth treated with root canals or pulpotomies?
[ ] yes [ ] no [ ] dk/u History of speech problems, speech therapy?
[ ] yes [ ] no [ ] dk/u Frequent oral habits (ex thumb sucking)?
[ ] yes [ ] no [ ] dk/u Clicking, locking in jaw joints?
[ ] yes [ ] no [ ] dk/u Any injuries to face, hand, neck?

Describe any dental or facial trauma: ____________________________
____

Is there a family history of jaw size imbalance? ____________________
____

Please list any medications or nutritional supplements that you take:

Medication	Taken for

Please describe any other pertinent medical history information you would like us to be aware of ______________________________________
____
____

RELEASE AND WAIVER

I have read the above questions and understand them. I will not hold my orthodontist or any member of 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 or dental insurance coverage.

I authorize and release any information regarding my orthodontic treatment to my dental and/or medical insurance company. I authorize the release of information as listed above in the HIPAA section to the listed individuals. I understand I may revoke this authorization by notifying ROS in writing of my intent to revoke authorization.

I have been offered a copy of the office Notice of Protected Health Information Privacy Practices which is located on the reception room bulletin board.

Signature ____ Date __________________________