ADVANTAGE ORTHODONTICS
Smiles by Dr. Ford

ADULT PATIENT HEALTH HISTORY INFORMATION

Patient's Name*

Gender: Male ☐ Female ☐

Preferred Name

Date of Birth*

Home Street Address*

City & State*

Zipcode*

Email (responsible party)*

Home Phone

Mobile Phone*

Other Family Members Seen By Us

Spouse or Significant Other Contact Name

Contact's Phone Number

Who Referred You To Our Office?

General Dentist's Name

Family Physician's Name

Dentist's Phone Number

Physician's Phone Number

Date of Last Exam

Date of Last Exam

May we contact you using? (check all that apply) - Text ☐ Email ☐ Mobile ☐

Marital Status - Single ☐ Married ☐ Divorced ☐ Widowed ☐

INSURANCE INFORMATION

Do you have dental insurance that includes an orthodontic benefit? Yes ☐ No ☐

If yes, please complete the following:

Primary Coverage

Policy Holder's Name*

Date of Birth*

Place of Employement*

Social Security Number*

Insurance Carrier*

Group Number*

Policy Number*

Carrier Phone # (if you'd like us to check on your benefit)

Secondary Coverage

Do you have secondary insurance that includes an orthodontic benefit? Yes ☐ No ☐

If yes, please complete the following:

Policy Holder's Name

Date of Birth

Place of Employement

Social Security Number

Insurance Carrier

Group Number

Policy Number

Carrier Phone # (if you'd like us to check on your benefit)

MEDICAL HISTORY

The following information is required to enable us to provide you with the best possible care. All information is strictly private and is protected by doctor-patient confidentiality. The orthodontist will review your medical history and explain any questions that you do not understand.

Are you being treated for any medical condition at this time or have you been treated for a medical condition within the past two years? Yes ☐ No ☐

If yes - please explain

Has there been a change in your health within the past two years? Yes ☐ No ☐

If yes - please explain

Are you currently taking any medications, non-prescription drugs, or herbal supplements? Yes ☐ No ☐

If yes - please explain

Do you have any allergies? If yes, please list using the categories below. Yes ☐ No ☐

Medications

Latex and/or rubber products

Other (e.g.; foods, hayfever, etc.)

Have you had your adenoids and/or tonsils removed? Yes ☐ No ☐

Do you have any conditions or therapies that could affect your immune system (e.g., leukemia, AIDS, HIV, radiotherapy, chemotherapy)? Yes ☐ No ☐

Have you ever been hospitalized for any illnesses or operations? Yes ☐ No ☐

If yes - please explain

Have you ever been treated by a physician for:

Yes	No	?	
☐	☐	☐	Cancer
☐	☐	☐	Heart Murmur
☐	☐	☐	Heart disease
☐	☐	☐	Rheumatic Fever
☐	☐	☐	Anemia
☐	☐	☐	Sickle Cell Anemia
☐	☐	☐	Abnormal Bleeding/Hemophilia
☐	☐	☐	Blood Tranfusions
☐	☐	☐	Hepatitis
☐	☐	☐	AIDS/HIV+
☐	☐	☐	Tuberculosis
☐	☐	☐	Liver Disease
☐	☐	☐	Kidney Disease
☐	☐	☐	Diabetes
☐	☐	☐	Arthritis

Yes	No	?	
☐	☐	☐	Cerebral Palsy
☐	☐	☐	Seizures
☐	☐	☐	Asthma
☐	☐	☐	Cleft Lip/Palate
☐	☐	☐	Speech or Hearing Problems
☐	☐	☐	Eye Problems/Contact Lenses
☐	☐	☐	Skin Problems
☐	☐	☐	Tonsils/Adenoids/Sinus Problems
☐	☐	☐	Endocrine Problems
☐	☐	☐	Artificial Joints/Valves
☐	☐	☐	Headache/Migranes
☐	☐	☐	Sleep Problems
☐	☐	☐	Radiation Therapy
☐	☐	☐	Osteoporosis (bisphosphonates)

Do you have any other medical conditions? Yes ☐ No ☐

If yes - please explain

Are you in good health? Yes ☐ No ☐

Women: Are you breastfeeding or pregnant? Yes ☐ No ☐

If pregnant - what is the due date?

DENTAL HISTORY

What concerns do you have about your teeth/smile?

Please explain

Are you nervous during dental treatment? Yes ☐ No ☐

Are you a mouth-breather while sleeping or awake (or both?) Yes ☐ No ☐

Have you ever had a habit such as thumb or finger sucking, nail biting, lip sucking, grinding teeth, or an unusual swallow pattern? Yes ☐ No ☐

Have you ever been informed of any missing or extra permanent teeth? Yes ☐ No ☐

Have there been any injuries to your face, mouth, or teeth? Yes ☐ No ☐

Have you experienced any jaw joint noises, pain, or limited movement? Yes ☐ No ☐

Have you previously consulted an orthodontist? Yes ☐ No ☐

Has any member of your family had orthodontic treatment? Yes ☐ No ☐

Yes	No	?	
☐	☐	☐	Have you ever experienced any complications following dental treatment?
☐	☐	☐	Are you currently having any dental treatment?
☐	☐	☐	Have you had a cavity in the last year?
☐	☐	☐	Have you ever been told that you had periodontal (gum) disease?
☐	☐	☐	Have you ever been told you had bone loss around your teeth?
☐	☐	☐	Do your gums bleed when brushed?
☐	☐	☐	Have you ever injured your teeth?
☐	☐	☐	Have you ever injured your jaws or face?
☐	☐	☐	Have you ever had problems with your jaw joints (TMJD)?

PATIENT CONSENT

Privacy of your personal health information is an important part of our office's providing you with quality dental care. We understand the importance of protecting your personal health information. We are committed to collecting, using and disclosing your personal health information responsibly. We also try to be as open and transparent as possible about the way we handle your personal health information. It is important to us to provide this service to our patients.

In this office, Dr. Doug Ford is the contact person for personal health information related matters. All staff members who come into contact with your personal health information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

- Only necessary information is collected about you.
- We only share your information with your consent.
- Storage, retention and destruction of your personal health information complies with existing legislation, and privacy protection protocols.
- Our privacy protocols comply with ADA standards.

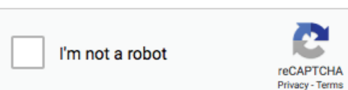
Do not hesitate to discuss our policies with Dr. Ford or any member of our office staff. By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal health information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal health information, we will seek your approval in advance.

☐ To the best of my knowledge, the above information is correct. If there is a change in my health history, or my medications change, I will inform the orthodontist at the next appointment.

☐ When appropriate or necessary, the orthodontist may send and discuss my health information with other involved health professionals.

Form Submission Date*	Signature*

Additional Comments/Notes



SEND