danville pediatric dentistry & orthodontics

## HEALTH HISTORY FORM- ADULT

PATIENT NAME_____ AGE_____ DOB____/_____/____
EMPLOYER_____ OCCUPATION_____
HOME ADDRESS_____CITY_____STATE_____ ZIP_____
HOME PHONE#_____ CELL PHONE#_____
EMAIL_____TIME AT THIS RESIDENCE_____ MARITAL STATUS_____
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____
HAVE WE TREATED ANY OTHER FAMILY MEMBERS? WHO:_____

## SPOUSE/ ADDITIONAL INFORMATION

NAME_____HOME PHONE#_____ CELL PHONE#_____
HOME ADDRESS_____CITY_____STATE_____ ZIP_____
TIME AT THIS RESIDENCE_____ MARITAL STATUS_____ RELATIONSHIP TO PATIENT_____
DOB____/_____/____ EMAIL _____
EMPLOYER_____OCCUPATION_____ NO. OF YEARS EMPLOYED_____

## DENTAL INSURANCE INFORMATION

INSURED NAME_____SS#_____ DOB____/_____/____
INSURANCE MEMBER ID_____ GROUP# _____INSURANCE CO_____
INSURANCE CO ADDRESS_____
PHONE_____ EMPLOYER_____
DO YOU HAVE DUAL COVERAGE? ☐Y ☐N - IF YES, INSURED NAME_____ SS#_____
MEMBER ID_____ GROUP#_____INSURANCE CO_____
EMPLOYER_____ INSURANCE CO ADDRESS_____

## MEDICAL/DENTAL HISTORY

PHYSICIAN'S NAME_____ PHONE#_____
DENTISTS NAME_____ PHONE#_____

☐**Y** ☐**N** ARE YOU CURRENTLY UNDER ANY MEDICAL TREATMENT? IF SO WHAT KIND?_____
☐**Y** ☐**N** DO YOU HAVE ANY PAIN, CLICKING, AND/OR POPPING NOISES IN THE JAW?
☐**Y** ☐**N** ARE YOU AWARE OF EITHER CLENCHING OR GRINDING OF TEETH? HISTORY OF NIGHT GUARD? ☐**Y** ☐**N**
☐**Y** ☐**N** DO YOU HAVE FREQUENT HEADACHES? HOW OFTEN?_____
☐**Y** ☐**N** DO YOU HAVE DIFFICULTY BREATHING THROUGH YOUR NOSE?
☐**Y** ☐**N** DO YOU HAVE EAR PROBLEMS? (ACHES, RINGING, DIZZINESS, FULLNESS)
☐**Y** ☐**N** DO YOU HAVE HABITS SUCH AS NAIL BITING, FINGER OR THUMB SUCKING, LIP OR CHEEK BITING?
☐**Y** ☐**N** DO YOU HAVE SPEECH PROBLEMS, OR ARE YOU IN SPEECH THERAPY?
☐**Y** ☐**N** HAVE YOU HAD YOUR TONSILS AND/ OR ADENOIDS REMOVED?
☐**Y** ☐**N** HAS THERE BEEN ANY HISTORY OF: ☐**JOINT SWELLING** ☐**ASTHMA** ☐**TB** ☐**AIDS** ☐**HIV** ☐**KIDNEY** ☐**LIVER CONDITION** ☐**EPILEPSY** ☐**RHEUMATIC FEVER** ☐**OTHER MAJOR ILLNESSES?**_____
☐**Y** ☐**N** DO YOU BLEED EASILY? **ANEMIC?** ☐**Y** ☐**N**
☐**Y** ☐**N** IS THERE A TENDENCY TO FAINT OR BECOME DIZZY?
☐**Y** ☐**N** DO YOU HAVE ALLERGIES? (LATEX, SULFUR, PENICILLIN, NOVACAINE, ETC.)_____
☐**Y** ☐**N** ARE YOU CURRENTLY TAKING ANY MEDICATIONS? LIST:_____
☐**Y** ☐**N** DO YOU HAVE A HEART CONDITION? ARE YOU PRE-MEDICATED? ☐**Y** ☐**N** CARDIOLOGIST:_____
☐**Y** ☐**N** ARE YOU CURRENTLY PREGNANT? **DUE DATE**_____
☐**Y** ☐**N** HAS YOUR CHILD BEEN DIAGNOSED WITH SLEEP APNEA?
☐**Y** ☐**N** DO YOU USE ANY SUBSTANCES? SUCH AS A VAPE OR CIGARETTES
☐**Y** ☐**N** ANY HISTORY OF FACIAL TRAUMA OR INJURIES TO THE TEETH? _____
☐**Y** ☐**N** ANY PERMANENT TEETH, OTHER THAN WISDOM TEETH EXTRACTED?_____
ANY OTHER MEDICAL CONCERNS NOT LISTED ABOVE:_____

SIGNATURE_____ DATE_____