SHER SMILES
ORTHODONTICS & PERIODONTICS

Confidential Adult Patient Health History and Information

Date:_____

Confidential Responsible Party Information

Name: _____ Gender: M / F Marital Status: _____
Last First Middle

Residence: _____ Own: _____ Rent: _____
Street City State Zip

Billing Address: _____
Street City State Zip

How long at this address: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____ **Appt. Reminder: Text / Email / Both**

Social Security No.: _____ Birthdate: _____ Relationship to Patient_____

Employer: _____ Occupation: _____ Military Pay Grade: _____ No Years Employed: _____

Spouse's Name: _____
Last First Middle

Cell Phone: _____ Email: _____ **Appt. Reminder: Text / Email / Both**

Social Security No.: _____ Birthdate: _____ Work Phone: _____

Employer: _____ Occupation: _____ Military Pay Grade: _____ No Years Employed: _____

Confidential Patient Information ☐ Check this box if same as above

Name: _____ Social Security No.: _____
Last First Middle

Residence: _____
Street City State Zip

Home Phone: _____ Birthdate: _____

Employer: _____ Occupation: _____ Military Pay Grade: _____ No Years Employed: _____

Insurance Information

Policy Holder's Name: _____ D.O.B.: _____ Social Security No.: _____

Insurance Company: _____ ID No: _____ Group No.: _____

Insurance Company Address: _____ Insurance Co. Phone: _____

Policy Holder's Employer: _____

Do you have dual coverage?: Yes / No If yes, Policy Holder's Name / Employer: _____

Insurance Company: _____ ID No: _____ Group No.: _____

Insurance Company Address: _____ Insurance Co. Phone: _____

Emergency Contact Information

Name of Emergency Contact: _____ Relationship: _____

Address: _____ Phone: _____
Street City State Zip

Whom may we thank for referring you to our office?_____

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Adult Patient Dental History Information

What is your main orthodontic problem(s)? _____

Are you sensitive about the appearance of your teeth or facial features (nose, chin, lips, etc)? _____

Are you interested in Traditional Braces? _____

Have you had an orthodontic consultation? Yes _____ No _____ If yes, when? _____

Has anyone in the family received orthodontic treatment from Sher Smiles? Yes _____ No _____

If yes, who? _____

Name of your current general dentist: _____ How many years? _____

Frequency of dental checkups? _____ Date of last dental exam: _____

Are there any needed restorations? Yes _____ No _____

Date restorations will be completed? _____

Please check any of the following that apply and explain in the box below:

- ❑ Are you apprehensive about dental care?
- ❑ Have you had any trouble associated with dental treatment?
- ❑ Have you had any teeth extracted?
- ❑ Have you injured or broken any teeth?
- ❑ Do you have any discomfort from teeth?
- ❑ Do you have any missing teeth?
- ❑ Do you have any extra teeth?
- ❑ Do you receive regular fluoride treatment?
- ❑ Do you have discomfort from gums?
- ❑ Are you aware of any swellings or growth in your mouth?
- ❑ Do you have frequent canker sores
- ❑ Have you had any injuries to either jaw?
- ❑ Do you chew on objects such as pens?
- ❑ Do you have regular jaw pain?
- ❑ Do you have limited jaw movement?
- ❑ Do your jaws click or pop?
- ❑ Do you have any trouble eating, chewing or swallowing?
- ❑ Do you habitually grind or clench teeth?
- ❑ Are you in speech therapy currently?
- ❑ Have you had any injuries to you face or mouth?
- ❑ Do you breathe with your mouth open or lips parted?

If you have checked any of the above, please explain:

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Adult Patient Medical History Information

Name & Location of Physician: _____

Are you in good health? _____ Date of last physical: _____

Are you presently under the care of a physician for any illness? _____ Please specify below.

Do you have a history of major illness or been hospitalized? _____ Please specify below

Is there anything you would like to talk to the doctor about in private? _____

Please check any of the following that apply and explain in the box below:

- ❑ Have you seen a medical specialist?
- ❑ Do you have a tendency to catch colds?
- ❑ Do you have an allergy to latex?
- ❑ Do you have an allergy to metals?
- ❑ Do you have any drug allergies / sensitivities?
- ❑ Do you require pre-medications?
- ❑ Are you taking any drugs or medications?
- ❑ Have you ever received Bisphosphonate treatment or other bone building medications? (e.g. Fosamax, Actinol, Bonival)
- ❑ Do you have gastric reflux?
- ❑ Are you pregnant or breastfeeding?

Please check any of the following for which the patient has been treated and explain in the box below:

- ❑ AIDS / HIV
- ❑ Asthma
- ❑ Arthritis
- ❑ Artificial joints
- ❑ Bone disorders
- ❑ Cancer
- ❑ Cerebral Palsy
- ❑ Diabetes
- ❑ Emotional disorder
- ❑ Endocrine problems
- ❑ Fainting or dizziness
- ❑ Frequent headaches or neck aches
- ❑ Heart trouble, defect or murmur
- ❑ Hepatitis
- ❑ Hormone Therapy
- ❑ Jaundice
- ❑ Kidney problems
- ❑ Liver problems
- ❑ Low / High blood pressure
- ❑Multiple Sclerosis
- ❑ Nervous disorder
- ❑ Osteoporosis
- ❑ Prolonged bleeding
- ❑ Rheumatic Fever
- ❑ Sickle Cell Anemia
- ❑ Sleep Apnea / Snoring
- ❑ Stomach ulcers
- ❑ Tuberculosis
- ❑ Thyroid problems
- ❑ Unusual growth patterns

If you have checked any of the above, please explain:

I authorize the release of any necessary dental or medical records to Sher Smiles for this patient. Records may be discussed with other health care providers and / or for educational purposes. I understand that where appropriate, credit bureau reports may be obtained.

Signature of Responsible Party _____ Date" _____