LAMPARSKI ORTHODONTICS

ADULT MEDICAL HISTORY

Patient Information

Date ______________________ Male ________ Female ________

Patient's Name ______________________ Nickname ______________________

Address ______________________ E-mail ______________________

Home Phone ____________ Cell Phone ____________ Birth Date ________ Social Security # ____________

Children/Siblings/Spouse (Name and Age) ______________________

Emergency Contact ______________________ Phone ____________ Relationship ____________

How did you hear about our office? ______________________

Employer ______________________ Occupation ______________________

Address ______________________ Phone ____________ How Long? ____________

Insurance Information

Marital Status: Single Married Widowed Divorced Separated Domestic Partner

Primary

Insurance Company Name ______________________ Insurance Company Phone ____________

ID # ____________

Insurance Company Address ______________________ Group or Plan ____________

Insured's Name ______________________ Insured's Birth Date ____________

Relationship ______________________ Insured's Social Security # ______________________

Insured's Employer ____________ Employer's Address ______________________

Secondary

Insurance Company Name ______________________ Insurance Company Phone ____________

ID # ____________

Insurance Company Address ______________________ Group or Plan ____________

Insured's Name ______________________ Insured's Birth Date ____________

Relationship ______________________ Insured's Social Security # ______________________

Insured's Employer ____________ Employer's Address ______________________

Dental History

What goals do you want orthodontics to accomplish?				Dentist / last visit
Past dental or facial trauma Yes No	Accidents or surgery to face, neck, mouth or teeth	Teeth broken, loosened or knocked out		Missing Teeth
Jaw joint problems Yes No	Explain	Frequent headaches	Clenching or grinding	
Oral problems Yes No	Canker/cold sores	Swollen/bleeding gums	Habits: thumb/finger	Speech
Difficulty chewing or swallowing Yes No	Previous orthodontic treatment or consultations	Orthodontist	Result	
Family members had orthodontics Yes No	Orthodontist	Result		
Does anyone in the family have a similar dental condition, crowded, retruded or protruded teeth, protruding lower jaw or receding chin?				

Medical History

Present health: Excellent Good Fair Poor		Physician
Ever hospitalized Yes No	Explain	**Do you have any of the following?**
Chronic diseases Yes No	Explain	□ AIDS/HIV+
Presently under physician care Yes No	Explain	□ Epilepsy
Presently on medication Yes No	Explain	□ TB
Allergies to latex or metal Yes No	Other allergies	□ Venereal disease
Complications to previous treatment Yes No	Explain	□ Rheumatic fever
Do you smoke or use tobacco Yes No	Explain	□ Heart murmur / defect
Any diseases, conditions or problems the orthodontists should know about?		□ Artificial joint
		□ Hemophilia
		□ Emotional problems

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY.

I understand the information I provided is correct to the best of my knowledge and it is my responsibility to inform this office of changes in my medical status. I understand I am responsible for payment of services rendered and also responsible for paying any co-payment and/or deductibles my insurance does not cover. **I authorize the doctors and staff to perform the dental services I need.**

Signature Date