ADULT HEALTH HISTORY

The following information is required to be filled out accurately and completely to become a patient of record. Please do not leave any lines blank. Feel free to ask any staff member if you have any questions.

Whom may we thank for referring you? ______________________________

What else brought our office to your attention? ☐ Our sign or location ☐ Phone Book ☐ Advertisement ☐ Website ☐ Other Patient

Are other family members' patients here? If so, please list: ______________________________

____

How many dentists have you seen in the past 10 years? ________

Please list your previous dentist and reason for leaving: ______________________________

____

PERSONAL INFORMATION

First Name ____________________ MI ____ Last Name ____________________

Birthdate _______/_______/_______ SS# ______________ ☐ Male ☐ Female

Home Address ______________________________

Home Phone (_____) _____-________ Best time to call ______________

Marital Status ☐Single ☐ Married ☐ Divorced ☐ Widowed

Employer ____________________ Occupation ______________

Address ______________________________

Work Phone (_____) _____-________ Cell Phone (_____) _____-________

Person to contact in an emergency ______________________________

Emergency contact phone # (_____) _____-________ Relationship ______________

Email Address ____________________@______________

INSURANCE INFORMATION

Are you currently covered by dental insurance? ☐ My own ☐ Spouse's ☐ Parent ☐ None

Insurance Carrier ____________________ Group # ______________

Address ______________________________

Phone (_____) _____-________ Deductible $__________ Max Annual Benefit $__________

MEDICAL INFORMATION

Your current health is: ☐ Good ☐ Fair ☐ Poor Smoker? ☐ Yes ☐No

Are you currently under the care of a doctor? ☐ Yes ☐No

Conditions being treated: ______________________________

____

Doctor's name: ______________ Doctor's Phone (_____) _____-________

Women: Are you pregnant? ☐ Yes ☐No Taking birth control? ☐ Yes ☐No

Please list any allergies and/or adverse reactions: ______________________________

____

Please list any medications and/or drugs you are taking: ______________________________

____

____

Turn over to complete this form

❖ **Have you had or currently have any of the following conditions? Please check all that apply:**

(All patient information is highly confidential.)

____High Blood Pressure	____Thyroid Disease	____Glaucoma	____Artificial Hip/Joint
____Heart Murmur	____Arthritis/Gout	____Hemophilia	____Lung Disease
____Rheumatic Fever	____Stroke	____Chemotherapy	____AIDS (HIV)
____Heart Attack	____Diabetes	____Ulcers	____Asthma
____Mitral Valve Prolapse	____Psychiatric Care	____Heart Surgery	____Kidney Trouble
____Liver Disease/ Cirrhosis	____Blood Disease	____Fainting	____Tuberculosis
____Drug/Alcohol Abuse	____Epilepsy/Seizures	____Hepatitis	____Cancer
____Anemia	____Cardiac Pacemaker	____Allergies	____Sexually Transmitted Disease
____Other: (please list)	________________		

DENTAL INFORMATION

Are your teeth sensitive to hot, cold or sweets?	☐ Yes	☐No
Do you have any pain in or around your teeth?	☐ Yes	☐No
Do you have any sores or lesions in or around your mouth?	☐ Yes	☐No
Do you have any pain in your jaw or near your jaw?	☐ Yes	☐No
Do you clench or grind your teeth?	☐ Yes	☐No
Have you had any orthodontic treatment in the past?	☐ Yes	☐No
Do you wear a removable partial/denture?	☐ Yes	☐No
If yes, are you satisfied with them?	☐ Yes	☐No

When was your last dental exam? ______________________________

What concerns do you have about your teeth, gums, or mouth?

____

Are you satisfied with the appearance of your teeth and/or smile? ☐ Yes ☐No

If NO, what would you like changed? ______________________________

____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect or omitting information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child/dependant during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my children/dependents. I understand that insurance will most likely not pay 100% of my dental services and I will be responsible for whatever insurance does not pay. I verify that I have received and understand the patient information pamphlet. I agree to abide by all policies set forth in the patient information pamphlet. I acknowledge that I have received a copy of the Notice of Privacy Practices (HIPAA) from Buckeye Dental and Braces. Please note that without 24 hours notice, we reserve the right to charge for appointments cancelled or not attended. Patients who are more that 15 minutes late for their appointment may be rescheduled and assessed a missed appointment fee.

____ ____________

Signature of Patient (or parent/guardian if minor) Date

Changes to History(office use only)

1. ______ ____________ ______ 2. ______ ____________ ______ 3. ______ ____________ ______
   Date Initial Date Initial Date Initial
4. ______ ____________ ______ 5. ______ ____________ ______ ____________________
   Date Initial Date Initial