MEDICAL HISTORY & INFORMATION FORM

Dr. D's Smiles

TODAY'S DATE _____

DACZKOWSKI ORTHODONTICS

PATIENT INFORMATION

PATIENT NAME _____ FIRST NAME _____

PREFERS TO BE CALLED? _____ BIRTHDATE _____SEX Male/Female

WERE YOU REFERRED BY A DENTIST? Yes/No _____ IF SO, NAME _____

EMAIL ADDRESS FOR NOTIFICATIONS _____

NAME OF SCHOOL _____

RESPONSIBLE PARTIES

FATHER'S NAME _____ MOTHER'S NAME _____

FATHER'S ADDRESS _____ MOTHER'S ADDRESS _____

_____ _____

SSN _____ DOB _____ SSN _____DOB _____

CELL PHONE _____ CELL PHONE _____

HOME PHONE _____ HOME PHONE _____

EMAIL _____ EMAIL _____

Only complete the parties that are financially responsible. If responsible parties are divorced or separated, each responsible party must willingly agree to financial responsibility by signing the financial agreement and provide personal info or the parent/guardian bringing the child will be solely financially responsible.

ORTHODONTIC INSURANCE

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____

INSURED NAME _____ INSURED NAME _____

GROUP NUMBER _____ GROUP NUMBER _____

MEMBER ID# _____ MEMBER ID# _____

INSURANCE THRU COMPANY NAME? _____ INSURANCE THRU COMPANY NAME? _____

HOW DID YOU HEAR ABOUT US?

INTERNET SEARCH ☐ MOBILE PHONE SEARCH ☐ INSTAGRAM ☐ TWITTER ☐

MAIL OUT POSTCARD ☐ FACEBOOK ☐ A FRIEND ☐ OTHER _____

REFERRAL BY DENTIST _____HIS NAME SO WE CAN THANK HIM/HER _____

DENTAL HISTORY

PATIENT'S DENTIST _____YOUR LAST VISIT _____

HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? YES ☐ NO ☐

HAVE YOU HAD OR DO YOU PRESENTLY HAVE ANY OF THE FOLLOWING HABITS?

☐ THUMB OR FINGER SUCKING ☐ LIP BITING ☐ SNORING

☐ GRINDING TEETH AT NIGHT ☐ MOUTH BREATHING

HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? ☐ YES ☐ NO

ARE YOU AWARE OF ANY SORES, LUMPS OR IRRITATED AREAS IN THE MOUTH? ☐ YES ☐ NO

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? ☐ YES ☐ NO

HIS NAME _____ WHEN _____

HAVE YOU BEEN TREATED FOR ☐ BAD BITE ☐ TMJ ☐ PERIODONTAL DISEASE

IF SO, BY WHOM _____ ☐ NO

DO YOU HAVE ANY SPEECH PROBLEMS ☐ YES ☐ NO

ARE YOU FRIGHTENED OF ORTHODONTIC TREATMENT ☐ YES ☐ NO

ARE YOU CONCERED ABOUT THE APPEARANCE OF YOUR TEETH ☐ YES ☐ NO

IS THERE ANYTHING YOU WOULD LIKE TO CHANGE ABOUT YOUR SMILE ☐ YES ☐ NO

IF SO, WHAT _____

REASON FOR CONSULTATION? _____

HAS THERE EVER BEEN ANY ORTHODONTIC TREATMENT FOR ANY OTHER MEMBER OF THE FAMILY?

☐ YES ☐ NO WERE YOU SATISFIED WITH THE RESULTS ☐ YES ☐ NO WHO? _____

MEDICAL HISTORY

IS YOUR GENERAL HEALTH GOOD ☐ YES ☐ NO ARE YOU UNDER THE CARE OF A PHYSICIAN AT THIS TIME?

☐ YES ☐ NO EXPLAIN _____

_____

NAME OF YOUR FAMILY PHYSICIAN? _____ARE YOU TAKING ANY MEDICATIONS?

☐ YES ☐ NO IF SO, NAME THEM _____

_____

IS THE PATIENT ALLERGIC TO ANY MEDICATION ☐ YES ☐ NO DATE OF LAST PHYSICAL _____

HAS THE PATIENT EVER TAKEN ANY DIET MEDICATION ☐ YES ☐ NO NAME _____

HAS THE PATIENT HAD TONSILS AND/OR ADENOIDS REMOVED ☐ YES ☐ NO AGE _____

HAS THE PATIENT EVER HAD SERIOUS ILLNESS OR BEEN HOSPITALIZED? EXPLAIN _____

_____

DOES THE PATIENT HAVE ANY SPECIAL PROBLEMS NOT LISTED _____

HAS THE PATIENT EVER BEEN ADVISED BY THEIR PHYSICIAN TO TAKE AN ANTIBIOTIC PRIOR TO ANY DENTAL

TREATMENTS ☐ YES ☐ NO NAME OF THE ANTIOBIOTIC? _____

WHAT IS THE PATIENT'S HEIGHT _____ WEIGHT _____ HAS THE PATIENT SHOWN SIGNS OF

INCREASED GROWTH RECENTLY ☐ YES ☐ NO HAS THE PATIENT REACHED PUBERTY ☐ YES ☐ NO

FATHER'S HEIGHT _____ MOTHER'S HEIGHT _____ SIBLINGS HEIGHT _____

DOES THE PATIENT NOW OR HAVE THEY EVER HAD ANY OF THE FOLLOWING

☐ YES ☐ NO TUBERFULOSIS
☐ YES ☐ NO ADD
☐ YES ☐ NO HIGH BLOOD PRESSURE
☐ YES ☐ NO HEART CONDITION
☐ YES ☐ NO LIVER DISEASE
☐ YES ☐ NO HEPATITIS (TYPE? ____)
☐ YES ☐ NO HEART ANGINA
☐ YES ☐ NO DRUG ADDICTION
☐ YES ☐ NO HERPES (ORAL-COLD SORES)

☐ YES ☐ NO LUNG DISEASE
☐ YES ☐ NO ENDOCARDITIS
☐ YES ☐ NO KIDNEY TROUBLE
☐ YES ☐ NO LOW BLOOD PRESSURE
☐ YES ☐ NO HEART PACEMAKER
☐ YES ☐ NO PSYCHIATRIC TREATMENT
☐ YES ☐ NO VENEREAL DISEASE
☐ YES ☐ NO HEART ATTACK (CORONARY)
☐ YES ☐ NO HEADACHES

☐ YES ☐ NO MITRAL VALVE PROLAPSE

☐ YES ☐ NO EARACHES

☐ YES ☐ NO INFLAMMATORY RHEUMATISM

☐ YES ☐ NO ARTIFICIAL HEART VALVE

☐ YES ☐ NO ALLERGIES

☐ YES ☐ NO ULCERS

☐ YES ☐ NO HEART MURMUR

☐ YES ☐ NO JAW PAIN

☐ YES ☐ NO PROSTHETIC JOINT

☐ YES ☐ NO ANEMIA

☐ YES ☐ NO EMOTIONAL PROBLEMS

☐ YES ☐ NO EPILEPSY

☐ YES ☐ NO GLAUCOMA

☐ YES ☐ NO FAINTING SPELLS

☐ YES ☐ NO BLOOD DISSORDER/BLEEDING

☐ YES ☐ NO CONGENITAL HEART DISEASE

☐ YES ☐ NO JAW CLICKING

☐ YES ☐ NO ARTHRITIS

☐ YES ☐ NO HEART SUGERY, WHEN_____

☐ YES ☐ NO ALLERGIES TO METAL

☐ YES ☐ NO STROKE

☐ YES ☐ NO RHEUMATIC FEVER

☐ YES ☐ NO ASTHMA

☐ YES ☐ NO TONSILLITIS

☐ YES ☐ NO XRAY CANCER RADIATION

☐ YES ☐ NO AIDS OR HIV POSITIVE

☐ YES ☐ NO DIABETES

☐ YES ☐ NO OTHER _____

☐ I HAVE COMPLETED THE HEALTH QUESTIONNAIRE AND CERTIFY THAT THE PRECEDING INFORMATION IS TRUE AND CORRECT. THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE INFORMATION NOT DISCLOSED. I GRANT AUTHORITY TO THE DOCTOR AND STAFF TO PERFORM ALL PROCEDURES AND TREATMENTS IN THE PATIENT'S BEST INTERST. I UNDERSTAND THAT, WHERE APPROPRIATE, CREDIT BUREA REPORTS MAY BE OBTAINED. I ALSO AGREE THAT MY TYPED NAME IS MY CONSENT ON THIS FORM FOR ELECTRONIC SIGNATURE IN ACCORDANCE WITH THE UNITED STATES UNIFORM ELECTRONIC TRANSACTIONS ACT FOR ECOMMERCE.

_____ _____

PATIENT ADULT OR PARENT/GUARDIAN NAME **TYPE PATIENT NAME**

_____

RESPONSIBLE PARTY VERIFICAION SIGNATURE

Once you complete the form, email form doc to patientcoordinator@daczkowskiortho.com