Medical Dental History From

PATIENT

Date_____

Patient's Last Name_____ First Name_____ Middle Initial____

Prefers To Be Called _____ Interests _____

Birth Date _____ Gender _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Address _____ City, State, Zip Code _____

Home phone _____Cell phone _____ Work phone _____

Email Address (es) _____

Occupation (if applicable) _____ Employer _____

School (if applicable) _____ Grade _____

If patient is a minor, please give parent(s) or guardian(s) name _____

Whom may we thank for referring you to our office _____

Has any member of your family or a friend been seen previously in this practice? _____

PARENT/GUARDIAN

☐ Please check if information is same as above

Patient lives with (check that apply) ☐ mother ☐ father ☐ stepmother ☐ stepfather ☐ grandparent(s) ☐ Other _____

Parent name _____ Title☐ Mr.☐ Mrs.☐ Ms.☐ Miss.☐ Dr.☐ Other _____

Occupation _____ Email address: _____

Address (if different) _____

Home phone _____ Cell phone _____ Work phone _____

Parent name _____ Title☐ Mr.☐ Mrs.☐ Ms.☐ Miss.☐ Dr.☐ Other _____

Occupation _____ Email address: _____

Address (if different) _____

Home phone _____ Cell phone _____ Work phone _____

DENTIST

Patient Dentist _____ Address, City, State _____

Last Seen _____ Reason _____ Next Appointment _____

Other dentists/dental specialists now being seen: Name_____ City, State _____

Reason _____

GENERAL INFORMATION

What is the main reason for seeking orthodontic treatment?_____

Who suggested that the patient might need orthodontic treatment? _____

Describe any previous orthodontic treatment or consultations _____

(If applicable) Does the patient play a musical instrument? _____

Brother/sister name _____ age _____ had orthodontic treatment? ☐Yes☐No If yes, where? _____

Brother/sister name _____ age _____ had orthodontic treatment? ☐Yes☐No If yes, where? _____

Brother/sister name _____ age _____ had orthodontic treatment? ☐Yes☐No If yes, where? _____

FINANCIAL RESPONSIBILITY

Who is responsible for this account? ☐ Parent/Guardian ☐ Self ☐ Other _____
Best contact information (if different from page 1) _____ City, State, Zip_____
Who will be responsible for bringing the patient to the appointments? _____

PHYSICIAN

Patient's Physician _____ Phone _____
Last Seen _____
Other physicians/health care providers being seen now:
Name _____ City, State, Zip _____
Reason _____
Name _____ City, State, Zip _____
Reason _____

PATIENT HEALTH INFORMATION

Do you think that any activities affect the face, teeth or jaws? How? _____
List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that the patient takes.
Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
Does the patient take antibiotic pre-medication before any dental procedures? ☐ Yes ☐ No
Has the patient ever had a substance abuse problem? _____
Does the patient chew or smoke tobacco? _____
Have you noticed any unusual changes in the patients face or jaws? _____
Any other physical problems? _____
How often do you brush? _____
How often do you floss? _____
Woman: Are you pregnant? ☐ Yes ☐ No Are you trying to become pregnant? ☐ Yes ☐ No

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation. For the following questions, please mark yes, no, or don't know/understand (dk/u).

MEDICAL HISTORY

Now or in the past has the patient had:

☐ **Yes** ☐ **No** ☐ **dk/u** Birth defects or hereditary problems?
☐ **Yes** ☐ **No** ☐ **dk/u** Bone fractures or major injuries?
☐ **Yes** ☐ **No** ☐ **dk/u** Any injuries to face, head, neck?
☐ **Yes** ☐ **No** ☐ **dk/u** Arthritis or joint problems?
☐ **Yes** ☐ **No** ☐ **dk/u** Cancer, tumor, radiation treatment or chemotherapy?
☐ **Yes** ☐ **No** ☐ **dk/u** Endocrine or thyroid problems?
☐ **Yes** ☐ **No** ☐ **dk/u** Diabetes or low sugar?
☐ **Yes** ☐ **No** ☐ **dk/u** Kidney problems?
☐ **Yes** ☐ **No** ☐ **dk/u** Immune system problems?
☐ **Yes** ☐ **No** ☐ **dk/u** History of Osteoporosis?
☐ **Yes** ☐ **No** ☐ **dk/u** Gonorrhea, syphilis, herpes, sexually transmitted diseases
☐ Yes ☐ No ☐ dk/u AIDS or HIV positive?
☐ Yes ☐ No ☐ dk/u Hepatitis, jaundice or other liver problems?
☐ Yes ☐ No ☐ dk/u Polio, mononucleosis, tuberculosis, pneumonia?
☐ Yes ☐ No ☐ dk/u Seizures, fainting spells, neurologic problem?
☐ Yes ☐ No ☐ dk/u Mental health disturbance or depression?
☐ Yes ☐ No ☐ dk/u History of eating disorder (anorexia, bulimia)?
☐ Yes ☐ No ☐ dk/u Frequent headaches or migraines?
☐ Yes ☐ No ☐ dk/u Stomach ulcer, hyperacidity, acid reflux?

☐ Yes ☐ No ☐ dk/u High or low blood pressure?
☐ Yes ☐ No ☐ dk/u Excessive bleeding or bruising tendency, anemia?
☐ Yes ☐ No ☐ dk/u Chest pain, shortness of breath, tire easily, swollen ankles
☐ Yes ☐ No ☐ dk/u Heart defects, heart murmur, rheumatic heart disease
☐ Yes ☐ No ☐ dk/u Angina, arteriosclerosis, stroke or heart attack?
☐ Yes ☐ No ☐ dk/u Skin disorder (other than common acne)?
☐ Yes ☐ No ☐ dk/u Eat a well balanced diet?
☐ Yes ☐ No ☐ dk/u Vision, hearing or speech problems?
☐ Yes ☐ No ☐ dk/u Frequent ear infections, colds, throat infections?
☐ Yes ☐ No ☐ dk/u Asthma, sinus problems, hay fever?
☐ Yes ☐ No ☐ dk/u Tonsil or adenoid condition?
☐ Yes ☐ No ☐ dk/u Frequently breathe through the mouth?
☐ Yes ☐ No ☐ dk/u Taken intravenous bisphosphonates such as Zometa (zolenddromic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?
☐ Yes ☐ No ☐ dk/u Taken oral bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders?

MEDICAL HISTORY CONTINUED

Has the patient had allergies or reactions to any of the following?

- ☐ Yes ☐ No ☐ dk/u Local anesthetics (novocaine, lidocaine, xylocaine)
- ☐ Yes ☐ No ☐ dk/u Latex (gloves, balloons)
- ☐ Yes ☐ No ☐ dk/u Aspirin
- ☐ Yes ☐ No ☐ dk/u Ibuprofen (Motrin, Advil)
- ☐ Yes ☐ No ☐ dk/u Penicillin
- ☐ Yes ☐ No ☐ dk/u Other antibiotics
- ☐ Yes ☐ No ☐ dk/u Metals (jewelry, clothing snaps)
- ☐ Yes ☐ No ☐ dk/u Acrylics
- ☐ Yes ☐ No ☐ dk/u Plant pollens
- ☐ Yes ☐ No ☐ dk/u Animals
- ☐ Yes ☐ No ☐ dk/u Foods
- ☐ Yes ☐ No ☐ dk/u Other substances _____

DENTAL HISTORY

Now or in the past, has the patient had:

- ☐ Yes ☐ No ☐ dk/u Erupting teeth very early or very late?
- ☐ Yes ☐ No ☐ dk/u Primary (baby) teeth removed that were not loose?
- ☐ Yes ☐ No ☐ dk/u Permanent or extra (supernumerary) teeth removed?
- ☐ Yes ☐ No ☐ dk/u Supernumerary (extra) or congenitally missing teeth?
- ☐ Yes ☐ No ☐ dk/u Chipped or injured primary or permanent teeth?
- ☐ Yes ☐ No ☐ dk/u Any sensitive or sore teeth?
- ☐ Yes ☐ No ☐ dk/u Bleeding gums, bad taste or mouth odor?
- ☐ Yes ☐ No ☐ dk/u Any lost or broken fillings?
- ☐ Yes ☐ No ☐ dk/u Jaw fractures, cysts, infections?
- ☐ Yes ☐ No ☐ dk/u Any teeth treated with root canals or pulpotomies?
- ☐ Yes ☐ No ☐ dk/u Frequent canker sores or cold sores?
- ☐ Yes ☐ No ☐ dk/u History of speech problems or speech therapy?
- ☐ Yes ☐ No ☐ dk/u Difficulty breathing through nose?
- ☐ Yes ☐ No ☐ dk/u Food impaction between the teeth?
- ☐ Yes ☐ No ☐ dk/u Mouth breathing habit or snoring at night?
- ☐ Yes ☐ No ☐ dk/u History of speech problems?
- ☐ Yes ☐ No ☐ dk/u Frequent oral habits (sucking finger, chewing pen, etc.)?
- ☐ Yes ☐ No ☐ dk/u Teeth causing irritation to lip, cheek or gums?
- ☐ Yes ☐ No ☐ dk/u Abnormal swallowing (tongue thrust)?
- ☐ Yes ☐ No ☐ dk/u Tooth grinding or clenching?
- ☐ Yes ☐ No ☐ dk/u Clicking, locking in jaw joints?
- ☐ Yes ☐ No ☐ dk/u Soreness in jaw muscles or face muscles?
- ☐ Yes ☐ No ☐ dk/u Ringing in ears, difficulty in chewing or opening jaw?
- ☐ Yes ☐ No ☐ dk/u Treated for “TMJ” or “TMD” problems?
- ☐ Yes ☐ No ☐ dk/u Any broken or missing fillings?
- ☐ Yes ☐ No ☐ dk/u Any serious trouble associated with previous dental treatment?
- ☐ Yes ☐ No ☐ dk/u Have you ever been diagnosed with gum disease or pyorrhea?
- ☐ Yes ☐ No ☐ dk/u Have you ever had an orthodontic consultation or treatment before now?

FAMILY MEDICAL HISTORY

Please explain if any close relatives (i.e. parents, siblings) have any of the following health problems. If so please explain.

Bleeding disorders _____

Diabetes _____

Arthritis _____

Severe allergies _____

Unusual dental problems _____

Jaw size imbalance _____

Other family medical conditions? _____

RELEASE AND WAIVER

I authorize release of any information regarding the patient’s orthodontic treatment to the dental and/or medical Insurance Company. _____ Initial

I give my consent that Byrdsmiles Orthodontics may use the patient’s image on their social media. _____ Initial

I have read the above questions and understand them. I will not hold my orthodontist or any Byrdsmiles orthodontic staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in the medical or dental health. _____ Initial

Parent/Guardian Signature _____ Date _____

Doctor Signature _____ Date _____

MEDICAL HISTORY UPDATES

Changes _____ Signature _____Date _____

Acknowledgement of Receipt of Notice of Privacy Practices

"You May refuse to Sign This Acknowledgement"

I _____, have reviewed a copy of Byrdsmiles Notice of Privacy Practices.
Parent/Guardian's name if patient is under 18 years of age

Print Name _____
Signature _____
Date _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

____ Individual refused to sign
____ Communication barriers prohibited obtaining the acknowledgement
____ An emergency situation prevented us from obtaining acknowledgement
____ Other (Please specify) _____

Insurance Consent

Byrdsmiles Orthodontics is out of network with all insurances. We do not accept any form of payment from dental insurance companies, including Medicare. Payment is expected at the time of service. Payment may be made via cash, personal check, or with any major debit/credit card.

It is the patient's responsibility to obtain a pre-authorization if required by your dental insurance company prior to the start of your orthodontic treatment. Our relationship is with you, our patient, and not with your insurance carrier. Byrdsmiles Orthodontics does not determine and cannot accept responsibility for the reimbursement amount from your insurance carrier. It will be your personal responsibility to pursue reimbursement from them. Please let us know if we may provide you with the dental insurance claim form.

Parent/Guardian Signature _____ Date _____

The cost of your orthodontic treatment may vary depending on your individual needs and treatment plan. Our treatment coordinator will discuss with you the cost of treatment and payment plan options so that you are able to make the best choice for you and your smile. We will work with you to create a payment plan that fits your budget, and you will know what to expect before beginning treatment.

Drs. Talley, and Clark believe finances should not be a barrier to anyone receiving orthodontic treatment, and have trained their team to help find a payment option that will work for you.