MEDICAL & DENTAL HISTORY Adult

GENERAL INFORMATION

Patient Name____

Address_______________________________ City___________________

State_____ Zip________ Email____________________________________

Home Phone______________ Cell Phone______________ Work Phone____________

Employment______________________________ Occupation_______________

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced ❑ Partnered

Spouse's Name____ Occupation__________

In case of emergency who should be notified?____________________ Phone_____________

Whom may we thank for referring you?____

Reason for seeking orthodontic treatment____

Today's Date ____________

Age ____________

Sex: ❑ M ❑ F

Birthday ____________

INSURANCE INFORMATION

Orthodontic Insurance Coverage: ❑ Yes ❑ No

Primary Insurance Co.______________________________ Subscriber_________________

Social Security Number______________________________ Date of Birth_______________

Secondary Insurance Co.____________________________ Subscriber_________________

Social Security Number______________________________ Date of Birth_______________

I authorize Cook Orthodontics, P.C. to submit insurance claims on my behalf. My signature also serves as my consent for insurance benefits to be assigned to Cook Orthodontics, P.C. I understand that I am financially responsible for all charges whether or not paid by insurance.

____________________________ ________________________ ______________

Signature Print Name Date

DENTAL HISTORY

Patient's Dentist________________________ City______________________ Phone__________

Last check-up/cleaning__________________

Check "Y" for yes or "N" for no to indicate if you have had any of the following:

Y	N		Y	N	
❑	❑	Bleeding, swollen, or tender gums	❑	❑	Grind the teeth
❑	❑	Burning sensation on tongue	❑	❑	Periodontal treatment
❑	❑	Chewing/smokeless tobacco	❑	❑	Permanent tooth extractions
❑	❑	Cigarette, pipe, or cigar smoking	❑	❑	Previous orthodontic treatment
❑	❑	Clench the teeth	❑	❑	Prolonged thumb/finger sucking
❑	❑	Clicking, pain, popping in jaw joint	❑	❑	TMJ problems and/or treatment
❑	❑	Difficulty cleaning the teeth	❑	❑	Wisdom tooth problems

Dental problems not listed: ____

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COOK ORTHODONTICS, P.C.
300 Eagle Crest Dr.
Evansville, IN 47715
(812) 402-3485
www.cook-ortho.com

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MEDICAL & DENTAL HISTORY

Adult

MEDICAL HISTORY

Physician's Name________________________ City______________ Phone ____________

Are you under the care of a physician at the present time? ❑ Yes ❑ No

If so, for what? ____

Describe history of any hospitalizations or operations ______________________________

____

List any allergies to metal, latex, or medication ______________________________

Are you taking or have you ever taken a Bisphosphonate medication such as Fosamax, Actonel, Boniva? ❑ Yes ❑ No

List any medications you are currently taking and the reason why ______________________

____

Check "Y" for yes or "N" for no to indicate if you have had any of the following:

Y	N		Y	N		Y	N	
❑	❑	AIDS/HIV	❑	❑	Circulatory problems	❑	❑	Liver disorder
❑	❑	Allergies	❑	❑	Diabetes or Hypoglycemia	❑	❑	Lung/Respiratory disorder
❑	❑	Anemia	❑	❑	Emphysema	❑	❑	Mitral valve prolapse
❑	❑	Arthritis/Rheumatism	❑	❑	Epilepsy	❑	❑	Psychiatric care
❑	❑	Artificial heart valves	❑	❑	Eyes, ears, nose, or throat condition	❑	❑	Rheumatic fever
❑	❑	Artificial joints	❑	❑	Heart murmur	❑	❑	Sexually transmitted disease
❑	❑	Asthma	❑	❑	Heart problems	❑	❑	Sinus/Breathing problems
❑	❑	Birth defects/ hereditary disorders	❑	❑	Hepatitis Type ______	❑	❑	Stomach ulcer or Hyperacidity
❑	❑	Cancer	❑	❑	High or low blood pressure	❑	❑	Stroke
❑	❑	Chemical dependency	❑	❑	Kidney disorder	❑	❑	Thyroid disorder
						❑	❑	Tuberculosis

Females:

❑ ❑ Are you pregnant? Due date:______________ Are you nursing? ❑ Yes ❑ No

❑ ❑ Are you anticipating becoming pregnant soon?

❑ ❑ Taking birth control pills?

Have you had any serious illnesses other than those above? If so, explain ______________________

____

I have read and understand the above questions. I will not hold Dr. Cook or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status I will so inform this practice.

________________________ ________________________ ____________

Signature Print Name Date

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize Cook Orthodontics, P.C. and the dental staff to perform necessary dental/orthodontic services I may need.

____

Signature

____ ____________

Print Name Date

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