ErikSwanson orthodontics
Exceptional Smiles

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WELCOME TO OUR PRACTICE!

Please take a few minutes to complete the following information so we can better care for your orthodontic needs.

Today's Date _____ **ADULT HEALTH HISTORY**

PATIENT INFORMATION

Patient's Name _____Birthdate_____ Age _____ ☐Male ☐Female
Home Address _____ Home Phone_____
City _____ State _____ Zip _____Mobile Phone_____
Email _____
Occupation _____Employer _____
Business Phone _____Mobile Phone _____
Has any other member of the family been a patient at this office? Names: _____
Who may we thank for referring you?_____
In case of emergency, who should we contact? _____ Phone _____

PATIENT MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____
Is the patient currently under medical treatment?_____ Is the patient taking any medications? _____
Has the patient ever had any serious illness and/or operations? _____
Has the patient had allergic reactions to any drugs or medications? _____ If yes, which ones?_____
Does the patient have allergies to nickel or latex? _____ (Women only) Is the patient pregnant? _____
Please check the box for each medical condition that applies:

☐Hyperactivity (ADD/ADHD)	☐Reports of grinding teeth	☐Snoring	☐Restless sleep
☐Mouth breathing	☐Sinus Problems	☐Frequent Colds	☐Fatigue
☐Asthma/Hay Fever	☐Tonsils/Adenoids Removed	☐Mood swings	☐Loss of interests
☐Sleep Study conducted	☐Frequent Headaches	☐Epilepsy	☐Cancer
☐Speech impairment	☐Bone Disorders	☐High Blood Pressure	☐Diabetes
☐Fainting/Dizzy Spells	☐Artificial Heart Valves	☐Heart Problems	☐Bleeding Excess
☐Kidney Disease	☐Liver Disease	☐Motor Difficulties	☐Stroke
☐Nervous Problems	☐Pneumonia	☐Radiation Treatment	☐Stomach Ulcer
☐Thyroid Problems	☐Arthritis/Rheumatism	☐Tuberculosis	☐Hearing Issues

☐Other _____

OVER →

Patient Name _____

PATIENT DENTAL HISTORY

Dentist's Name _____ Date of last visit _____
Date of last complete full mouth X-rays and/or Panorex X-ray _____
Please check the box for all that apply:

☐Bleeding Gums ☐Blisters on Lips/Mouth ☐Prone to Cavities ☐Missing Teeth
☐Extra Teeth ☐Any Teeth Extracted ☐Chewing Difficulties ☐Speech Difficulties
☐Tooth Grinding/Clenching ☐Severe Head and/or Facial Injuries_____
☐Pain or Clicking in the Jaw Joint (TMJ/TMD)
☐Jaw Locking on Opening or Closing _____

Have you ever consulted with an orthodontist? If so, when? _____
Have you ever had orthodontic treatment? If so, when? _____
Would you mind wearing braces to straighten your teeth? _____
What would you like orthodontic treatment to accomplish? _____
What concerns you most about orthodontic treatment?

☐Cost ☐Appearance ☐Length of Time ☐Pain ☐Effectiveness ☐Other _____

PRIMARY DENTAL INSURANCE

Person responsible for account (Last, First, MI) _____
Relationship to patient _____ Birthdate _____ Soc. Security # _____
Address _____
City _____ State _____ Zip _____ Home Phone _____
Responsible party employed by _____ Business Phone _____
Business Address _____ Occupation _____
Insurance Company _____ Insurance Phone _____
Insurance Company Address _____
Subscriber ID # _____ Group #_____

ADDITIONAL DENTAL INSURANCE

Insured Name (Last, First, MI) _____
Relationship to patient _____ Birthdate _____ Soc. Security # _____
Address _____
City _____ State _____ Zip _____ Home Phone _____
Insured employed by _____ Business Phone _____
Insurance Company _____ Insurance Phone _____
Insurance Company Address _____
Subscriber ID # _____ Group # _____

HIPAA COMPLIANCE DISCLOSURE

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

I understand that the information I have given is correct to the best of my knowledge, and that it will be held in the strictest confidence. I authorize release of any information regarding my treatment to my dental/medical insurance company. I will not hold my orthodontist or any member of his/her 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 my medical/dental health

Signature _____ _____Date _____