Shoff Orthodontics – For Adults over 18

PATIENT INFORMATION - Who may we thank for referring you to our office: _____
Have any other family members been treated in this office? Please list them _____

PATIENT INFORMATION
First Name_____Last Name_____Middle Initial_____Age_____Gender_____

Address_____City_____State/Zip_____

Date of Birth_____SS #: _____Employer_____Occupation_____
Spouse_____DOB_____Employer_____Occupation_____

DENTIST: Name of Dentist_____Last seen_____Reason for visit_____
PHYSICIAN: Name of Physician_____ Last seen_____Reason for visit_____

FINANCIAL RESPONSIBILTY: _____
Address if different from patients_____
Home Phone_____Cell Phone_____Email address_____
CONFIRMATIONS: We confirm appointments via email/text messaging therefore; please provide us with the following information:
Best Contact Information:
Patient Number_____□ Home □ Cell (if cell who is provider?) _____□ Work
Email address_____@_____._____
Spouse Number_____□ Home □ Cell (if cell who is provider?) _____□ Work
Email address_____@_____._____
PRIMARY DENTAL INSURANCE
Insurance _____Insurance phone #_____ID#_____Group#_____
(Policy holder's full name) _____DOB_____ Relationship _____
SECONDARY DENTAL INSURANCE
Insurance _____Insurance phone #_____ID#_____Group#_____
(Policy holder's full name) _____DOB_____ Relationship _____

MEDICAL HISTORY

YES	NO	UNK	
□	□	□	Any injuries to face, head neck
□	□	□	Arthritis or joint problems
□	□	□	Asthma, sinus problems, hay fever
□	□	□	Birth defects/hereditary problems
□	□	□	Bone fractures or major injuries
□	□	□	Cancer, tumor
□	□	□	Diabetes or low sugar
□	□	□	Do you eat a well-balanced diet
□	□	□	Difficulty breathing through nose
□	□	□	Endocrine or thyroid problems
□	□	□	Frequent ear infections, colds, throat infections
□	□	□	Do you frequently breathe through your mouth
□	□	□	Heart defects, murmur, rheumatic heart disease
□	□	□	Angina, arteriosclerosis, stroke or heart attack
□	□	□	Chest pain, shortness of breath, tire easily
□	□	□	Hepatitis, jaundice, or other liver problems
□	□	□	Immune system problems
□	□	□	History of osteoporosis
□	□	□	Kidney problems
□	□	□	Mental health disturbance or depression
□	□	□	Polio, mononucleosis, tuberculosis, pneumonia
□	□	□	Radiation treatment or chemotherapy
□	□	□	Stomach ulcer, hyperacidity, acid reflux
□	□	□	Sexually transmitted diseases/AIDS/HIV positive

YES	NO	UNK	
□	□	□	Seizures, fainting spells, neurologic problems
□	□	□	Skin disorder (other than acne)
□	□	□	Tonsil or adenoid condition
□	□	□	High or low blood pressure

DENTAL HISTORY

YES	NO	UNK	
□	□	□	Abnormal swallowing (tongue thrust)
□	□	□	Clicking, locking in jaw joints
□	□	□	Soreness in jaw muscles or face muscles
□	□	□	Problems with previous dental treatment
□	□	□	Any broken or missing fillings
□	□	□	Frequent headaches or migraines
□	□	□	Permanent or extra teeth removed
□	□	□	Supernumerary or congenitally missing teeth
□	□	□	Chipped or injured primary or permanent teeth
□	□	□	Any sensitive or sore teeth
□	□	□	History of gum disease/pyorrhea
□	□	□	Bleeding gums, bad taste or mouth odor
□	□	□	Jaw fractures, cysts, infections
□	□	□	Any teeth treated with root canals/pulpotomies
□	□	□	History of canker sores/cold sores
□	□	□	History of speech problems or speech therapy
□	□	□	History of eating disorder (anorexia, bulimia)
□	□	□	Excessive bleeding or bruising
□	□	□	Vision, hearing or speech problems
□	□	□	Food impaction between the teeth

YES NO UNK

□ □ □ Frequent oral habits (sucking finger, thumb)
□ □ □ Teeth causing irritation to lip, cheek or gums
□ □ □ Tooth grinding/clenching
□ □ □ Ringing in ears, difficulty in chewing/opening jaw
□ □ □ History of TMJ/TMD problems

Have you had allergies or reactions to any of the following?

YES NO UNK

□ □ □ Acrylics
□ □ □ Plant pollens
□ □ □ Animals
□ □ □ Foods
□ □ □ Latex (gloves or balloons)
□ □ □ Local anesthetics; Novocain/lidocaine/xylocaine
□ □ □ Medication allergies_____
□ □ □ Metals (Jewelry, clothing snaps)

PATIENT HEALTH INFORMATION

List any medications, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you take.

Medication_____Taken for_____
Medication_____Taken for_____
Medication_____Taken for_____

Have you ever taken any medications to strengthen your bones? YES □ NO □

Please describe_____

Do you take antibiotic pre-medication before dental procedures? □ YES □ NO

Do you/have you ever had a substance abuse problem? □YES □ NO

Do you chew or smoke tobacco? □ YES □ NO

Have you noticed any changes in your face or jaws?

_____

Any other physical problems?

_____

How often do you brush/floss? _____

Women: Are you pregnant □ YES □ NO

Are you trying to become pregnant? □ YES □ NO

FAMILY MEDICAL HISTORY

Have your parents or siblings ever had 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 _____

Any other information, not listed above that you feel will be important for Dr. Shoff to know?

_____

_____

GENERAL INFORMATION

What concerns you about your teeth? _____

Have you had a previous orthodontic treatment? Please describe._____

RELEASE AND WAIVER

I have read the above questions and understand them. 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 or dental health. I also understand that if I have insurance coverage with the above insurance company, I assign directly to Dr. Shoff all orthodontic benefits. I understand that an appropriate credit bureau report may be obtained. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier. I hereby authorize the doctor to release all information necessary to secure payment of benefits.

Signature _____ **Date** _____

_____ **Date** _____

Health History Reviewed by Dr. Robert C. Shoff, DDS

MEDICAL HISTORY UPDATES OR CHANGES

Date_____ Changes_____ Patient initials _____

Dental Staff Signature_____Date_____

Date_____ Changes_____ Patient initials _____

Dental Staff Signature_____Date_____

Date_____ Changes_____ Patient initials _____

Dental Staff Signature_____Date_____