ADULT Health History – Clauss Orthodontics

Date: _____

Biographical Information

First Name:	Last Name:	Nickname:	
Birthdate:	Gender:	Home Phone:	
Address:	City:	State:	Zip:

Financial Party Information

Employer Name and Phone Number:	Length of Employment:	Occupation:	
Cell #:	Want Appt. Reminder? ❑ Yes / ❑ No	Email:	Want Appt. Reminder? ❑ Yes / ❑ No

Marital Status: ❑ Married / Re-married ❑ Separated ❑ Divorced ❑ Single ❑ Widowed

Please list the name(s) and birthdate(s) of any children:

Referral Information

Please list the names of any friends or family currently in the practice:

Who may we thank for referring you to our practice? (**We have a referral thank you program. Ask us about it.)**

Please let us know of the ways you are familiar with Clauss Orthodontics: (Please check ALL that apply)

❑ Family Dentist/Physician referral: _____	❑ School referral	❑ Community Event
❑ Friend / Patient referral: _____	❑ Mail Postcard	❑ Sports Team Sponsorship
❑ Clauss Orthodontics staff referral: _____	❑ Ad at school	❑ Drive by / Signage
❑ Invisalign / Orthodontic web search	❑ Print ad	❑ Other: _____
❑ Website		

Dental History

Dentist Name:

Check-up Frequency:	Last Dental Cleaning:
Have you had an orthodontic consult or treatment? Yes No	If so, when?

What is your main orthodontic concern?

How will getting treatment positively impact you?? How would you define success?

Please rank items in order of greatest concern: ___ Results ___ Financial Arrangements ___ Clear Option ___ Treatment Time

Speech problems/therapy?	Yes No	Brush teeth daily?	Yes No	Floss teeth daily?	Yes No
Grind/clench teeth habitually?	Yes No	Injury to face/jaw/teeth/mouth?	Yes No	Use fluoride rinse daily?	Yes No
Oral finger/thumb/nail biting habits?	Yes No	Mouth breathing?	Yes No	Snores during sleep?	Yes No
Discomfort in teeth or gums?	Yes No	Pain in/near your ears?	Yes No	Frequent headaches?	Yes No
Premedication before dental treatment?	Yes No	Neck/shoulder pain?	Yes No	Frequently chews gum?	Yes No
Any missing or extra permanent teeth?	Yes No	Frequent sore throats?	Yes No	Had any teeth removed?	Yes No
Constant sore or bleeding gums?	Yes No	Difficulty chewing/swallowing food?	Yes No	Clicking jaw joint?	Yes No
Apprehensive about dental care?	Yes No	Pain or tenderness in either jaw?	Yes No		

If any of the above dental questions were answered "Yes," please explain:

Do you play a musical instrument with your mouth? If yes, please list all:

Medical History

Physician Name:	Date of last Physical:	Patient Health:

Are you presently under a physician's care? If yes, please explain:

List any medications currently being taken:

List drug allergies, latex allergy, or sensitivity:

Rheumatic Fever	Yes	No	Cancer	Yes	No	Family History of Cancer	Yes	No
Tuberculosis/Lung Disease	Yes	No	Liver Disease	Yes	No	Growth Problems	Yes	No
Had Radiation Treatment	Yes	No	Hemophilia	Yes	No	Kidney Disease	Yes	No
High Blood Pressure	Yes	No	Anemia	Yes	No	Heart Attack/Stroke	Yes	No
Prolonged Bleeding/Transfusion	Yes	No	Hepatitis	Yes	No	Bone Disorders/Loss	Yes	No
Treated for Emotional Problems	Yes	No	Heart Murmur	Yes	No	Seizures/Epilepsy	Yes	No
Extensive X-ray Therapy	Yes	No	Pneumonia	Yes	No	Nervous Disorders	Yes	No
Operations/Injuries of Head/Neck	Yes	No	Heart Disease	Yes	No	Latex/Metal Allergy	Yes	No
Congenital Heart Defect	Yes	No	Diabetes	Yes	No	Hormone Therapy	Yes	No
Handicaps/Disabilities	Yes	No	Asthma	Yes	No	Tumors/Growths	Yes	No
Rheumatism or Arthritis	Yes	No	HIV/AIDS	Yes	No	Endocrine Problems	Yes	No
Venereal Disease	Yes	No	Blood Disease	Yes	No	Tonsils/Adenoids Removed	Yes	No
Stomach or Intestinal Disease	Yes	No	History of fainting	Yes	No	Yellow Jaundice or Hepatitis	Yes	No
Night Sweats w/ weight loss/cough	Yes	No	Currently dieting	Yes	No	Ever Been Hospitalized	Yes	No
Slow Healing Wounds?	Yes	No				If female, are you pregnant?	Yes	No

If any of the above medical questions were answered "Yes," please explain:

Have you been ill for more than 5 days in the last year? If yes, please explain:

Allergic to any known materials resulting in hives, asthma, eczema, etc? If yes, please explain:

Signature: _____ Date: _____

Print Name: _____

Doctor Signature: _____ Date Reviewed: _____