ADULT HEALTH HISTORY ***GARY L. JONES, D.M.D.*** Date _____

PATIENT INFORMATION

Patient's Name _____ Patient's E-Mail_____Birth date _____

Address _____ Phone _____
Street City State Zip

Gender: Male Female General Dentist: _____ Employer: _____

Occupation_____ Work Phone _____ Marital Status: Married Separated Divorced Widowed Single

Do you have ORTHODONTIC Insurance?_____Name of Insurance Co._____Policy No._____ Group No._____

If Married: Spouse's Name _____Spouse's Employer : _____ Occupation : _____

Work Phone _____-_____ Cell Phone_____-_____ Whom may we thank for referring you to our office?_____

What do you think is your orthodontic problem?_____

RESPONSIBLE PARTY INFORMATION

Person responsible for account (if other than above patient) _____

Address _____
Street City State Zip
Phone _____ Birthdate _____ Relationship to patient_____Employer _____

No. Years Employed _____Occupation_____ Work Phone _____

EMERGENCY INFORMATION: Name of nearest relative not living with you: _____

Complete Address: _____ Phone: _____

MEDICAL HISTORY

Are you in good health? ___yes ___no Explain: _____
Any major or unusual illnesses? ___yes ___no Explain: _____
Currently being treated by a physician? ___yes ___no Explain: _____
Currently taking medication? ___yes ___no Explain: _____
Drug Allergies? ___yes ___no Explain: _____

Any premedications needed before dental procedures(ex. joint replacement or heart problems)? _____If so list:_____

Physician's Name: _____Address:_____Phone:_____

Please check if you have or have had any of the following:

Yes	No		Yes	No		Yes	No	
___	___	Anemia	___	___	Heart Problems	___	___	Glaucoma
___	___	Blood Disease	___	___	Tuberculosis	___	___	Adenitis
___	___	Prolonged Bleeding	___	___	Diabetes	___	___	Tonsils removed : Age _____
___	___	Jaundice	___	___	Endocrine Problems	___	___	Adenoids removed : Age _____
___	___	Rheumatic Fever	___	___	Bone Disorders	___	___	Asthma
___	___	Scarlet Fever	___	___	Epilepsy	___	___	Mouthbreathing- While awake/asleep?
___	___	Hepatitis	___	___	Herpes	___	___	Are you in a risk group for AIDS?

DENTAL HISTORY

Yes	N0	
___	___	Have you ever had any severe head or facial injuries? Explain: _____
___	___	Have you had a history of thumb or finger sucking? Stopped? _____ When? _____
___	___	Have you had any previous orthodontic treatment? If so, with whom? _____
___	___	Have any family members had orthodontic treatment?

Please check **if there is** a history of any of the following:

____ Clenching teeth	____ Headaches (more than normal)	____ Jaw joint Popping
____ Grinding teeth	____ Jaw joint Soreness	____ Ringing in the ears
____ Muscular soreness around Head & Neck	____ Jaw joint Clicking	

To the best of my knowledge, the above information is correct.
Patient's Signature: _____ **Date** _____

I give my permission to Dr. Jones and his staff to take necessary x-rays, photographs and impressions of my teeth for diagnostic and educational purposes.
Patient's Signature: _____ **Date** _____