CONFIDENTIAL

Medical Dental History Form for 18 and Over

PATIENT

Date _____Social Security # _____Title (circle one) **Mr. Mrs. Ms. Dr. Other** Birth Date_____

Patient's First name _____ Middle Initial_____Last Name_____

I prefer to be called _____What sex were you assigned on your birth certificate? (circle one) **Male Female**

What is your current gender identification? (circle one) **Male Female Other** What are your preferred pronouns? _____

Marital Status? (circle one) **Single Married Separated Divorced Widowed**

Home address _____ City, State, Zip code_____

Cell phone _____(use cell for SMS reminders?) **Y N** Work phone _____

E-mail address _____How did you hear about us?_____

Employer_____Occupation_____

CLOSEST RELATIVE

Spouse or closest relative's name(s) _____ Relationship to patient _____

Title Mr. Mrs. Miss Dr. Other Prefers to be called _____Address (if different than patient address)_____

_____City, State, Zip Code_____

Cell phone _____(ok to discuss treatment with?) **Yes No** Work phone _____

FINANCIAL RESPONSIBILITY

Who is primarily financially responsible for this account? _____D.O.B._____

Address _____ City, State, Zip _____

Cell phone _____Work phone _____Marital Status:_____

E-mail address_____ Social Security #_____

Employer _____Occupation_____

DENTAL INSURANCE

Primary policy holder's **full legal name** _____ D.O.B. _____

Social Security # _____Relationship to patient _____

Address and phone (if not listed above) _____City, State, Zip,_____

Employer _____ Occupation_____

Insurance company name _____ Group # _____ ID # _____Insurance Company address_____Insurance Co. Phone#_____

Secondary policy holder's **full legal name** _____D.O.B._____

Social Security #_____ Relationship to patient _____

Address and phone (if not listed above) _____City, State, Zip,_____

Employer _____Occupation _____

Insurance company name_____ Group # _____ ID # _____Insurance Company address_____Insurance Co. Phone#_____

Revised 2024

MEDICAL INSURANCE

Policy holder's full name _____D.O.B._____

Insurance company _____Insurance Company Address_____

DENTIST

Patient's Dentist _____ Address, City, State _____ Last seen _____ Reason_____ Next appointment _____ Other dentists/dental specialists now being seen: Name _____ City, State _____ Reason _____

PHYSICIAN

Patient's Physician _____ City, State _____

Last seen _____ Reason _____ Next appointment _____

Most recent physical exam _____

Other physicians/health care providers being seen now:

Name _____ City, State _____ Reason _____

Name _____ City, State _____ Reason _____

GENERAL INFORMATION

What concerns you about your teeth? _____

Who suggested that you might need orthodontic treatment?_____

Why did you select our office?_____

Have you had any previous orthodontic treatment? Please describe _____

Have any other family members been treated in this office? Please name them. _____

Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain. _____

PATIENT HEALTH INFORMATION

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

Do you take antibiotic pre-medication before any dental procedures? Yes No

Medication _____ Taken for _____ Medication _____ Taken for_____

Medication _____ Taken for _____ Medication _____ Taken for _____ Have you ever taken any medications to strengthen your bones? Please describe. _____

Do you or have you ever had a substance abuse problem?(circle one) **Yes No Current**

Do you currently suffer with, or have you suffered in the past with an eating disorder? (circle one) **Yes No Current** Have you chewed tobacco? (circle one) **Yes No Current** Smoked any substance or vaped?(circle one) **Yes No Current**

If yes, to above what is the frequency? _____

Have you noticed any changes in your face or jaws? _____

Any other physical problems? _____

How often do you brush? _____ How often do you floss? _____

Are you pregnant?(circle one) **Yes No** Are you trying to become pregnant? (circle one) **Yes No**

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation. For the following questions mark yes, no, or don't know/understand (dk/u).

MEDICAL HISTORY

Now or in the past, have you had:

Yes No DK/U (circle one)

Y N DK/U Have you ever taken intravenous medication for bone disorders or cancer such as bisphosphonates as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate)?

Y N DK/U Have you ever taken oral medication for bone disorders such as bisphosphonates Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate)?

Y N DK/U Hereditary or developmental conditions?

If Yes list:_____

Y N DK/U Bone fractures, or major injuries?

Y N DK/U Any injuries to face, head, neck?

Y N DK/U Arthritis or joint problems?

Y N DK/U Endocrine or thyroid problems?

Y N DK/U Diabetes or low sugar?

If Yes list specific diagnosis:_____

Y N DK/U Kidney problems?

Y N DK/U Cancer, tumor, radiation treatment or chemotherapy?

Y N DK/U Stomach ulcer, hyperacidity, acid reflux?

Y N DK/U Immune system problems?

Y N DK/U History of osteoporosis?

Y N DK/U Gonorrhea, syphilis, herpes, sexually transmitted diseases?

Y N DK/U AIDS or HIV positive?

Y N DK/U Hepatitis, jaundice or other liver problem?

Y N DK/U Polio, mononucleosis, tuberculosis, pneumonia?

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

Yes No DK/U (circle one)

Y N DK/U Latex (gloves, balloons)

Y N DK/U Metals (jewelry, clothing snaps)

Y N DK/U Acrylics

Y N DK/U Local anesthetics (novocaine, lidocaine, xylocaine)

Y N DK/U Aspirin

Y N DK/U Ibuprofen (Motrin, Advil)

Y N DK/U Penicillin

Y N DK/U Other antibiotics

Y N DK/U Plant pollens

Yes No DK/U (circle one)

Y N DK/U Seizures, fainting spells, neurologic problem?

Y N DK/U Mental health disturbance or depression?

Y N DK/U Vision, hearing, or speech problems?

Y N DK/U History of eating disorder (anorexia, bulimia)?

Y N DK/U Have you experienced any weight change in the past several months?

Y N DK/U High or low blood pressure?

Y N DK/U Excessive bleeding or bruising, anemia?

Y N DK/U Chest pain, shortness of breath, tire easily, swollen ankles?

Y N DK/U Heart defects, heart murmur, rheumatic heart disease?

Y N DK/U Angina, arteriosclerosis, stroke or heart attack?

Y N DK/U Skin disorder (other than common acne)?

Y N DK/U Do you eat a well-balanced diet?

Y N DK/U Frequent headaches or migraines?

Y N DK/U Frequent ear infections, colds, throat infections?

Y N DK/U Asthma, sinus problems, hayfever?

Y N DK/U Tonsil or adenoid condition?

Y N DK/U Do you frequently breathe through your mouth?

Any additional Health related issues or more details about current issues you would like to explain further? (ie: but not limited to, undergoing evaluation for autism, ashbergers) Any special needs we need to be aware of while treating you?

_____

_____

_____

DENTAL HISTORY

Now or in the past, have you had:

Yes No DK/U (circle one)

Y N DK/U Permanent or extra (supernumerary) teeth removed?

Y N DK/U Supernumerary (extra) or congenitally missing teeth?

Y N DK/U Chipped or injured primary or permanent teeth?

Y N DK/U Any sensitive or sore teeth?

Y N DK/U Bleeding gums, bad taste or mouth odor?

Y N DK/U Jaw fractures, cysts, infections?

Y N DK/U Any teeth treated with root canals or pulpotomies?

Y N DK/U "Gum boils," frequent canker sores or cold sores?

Y N DK/U History of speech problems or speech therapy?

Y N DK/U Difficulty breathing through nose?

Y N DK/U Food impaction between the teeth?

Y N DK/U Mouth breathing habit or snoring at night?

Y N DK/U History of speech problems?

Y N DK/U Do you currently use a CPap?

Yes No DK/U (circle)

Y N DK/U Abnormal swallowing (tongue thrust)?

Y N DK/U Tooth grinding or clenching?

Y N DK/U Clicking, locking in jaw joints?

Y N DK/U Soreness in jaw muscles or face muscles?

Y N DK/U Ringing in ears, difficulty in chewing or opening jaw?

Y N DK/U Have you ever been treated for "TMJ" or "TMD" problems?

Y N DK/U Any broken or missing fillings?

Y N DK/U Any serious trouble associated with previous dental treatment?

Y N DK/U Have you ever been diagnosed with gum disease or pyorrhea?

Y N DK/U Have you ever had an orthodontic consultation or treatment before now?

If Yes at what age?_____

Y N DK/U Teeth causing irritation to lip, cheek or gums?

Y N DK/U Frequent oral habits (sucking finger, chewing pen, etc.)?

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? _____

_____

_____

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature _____ Date_____

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.

Signature _____ Date_____

Bellow to be updated with office personnel, if needed, at follow-up visits before treatment starts

MEDICAL HISTORY UPDATES OR CHANGES

Changes _____

Patient Signature _____ Date_____

Dental Staff Signature _____ Date_____

Changes _____

Patient Signature _____ Date_____

Dental Staff Signature _____ Date_____

Changes _____

Patient Signature _____ Date_____

Dental Staff Signature _____ Date_____

PATIENT AUTHORIZATION FOR SPECIFIC DISCLOSURE OF PROTECTED HEALTH INFORMATION 18 and OLDER

I, the undersigned, hereby authorize Quad City Orthodontics, LLC to disclose certain protected health information about me.

Quad City Orthodontics, LLC is hereby authorized to disclose the following protected health information deemed necessary to provide comprehensive orthodontic diagnosis or treatment. Such as:

- All Medical Records
- X-Rays
- Treatment Recommendations

I understand that this request does not apply to: (1) certain health information that is not held in Quad City Orthodontics medical records; (2) psychotherapy notes; (3) information compiled in reasonable anticipation of or for litigation; and (4) other health information not subject to the right of access under HIPAA.

The information may be disclosed to collaborate with auxiliary health care providers in order to provide comprehensive treatment.

My signature below acknowledges that I understand that:

- I have the right to inspect or obtain a copy of the information to be disclosed. • This request does not apply to certain health information that is not held in Quad City Orthodontics, LLC's medical records.
- This request does not apply to information or records compiled in reasonable anticipation of litigation.
- This request does not apply to any other health information not subject to the right of access under HIPAA.
- I may refuse to sign or, at any time, may revoke this Authorization for any reason. I understand that if I revoke this authorization, I must do so by sending a written notice of revocation to Quad City Orthodontics, LLC, 2850 24th Street Rock Island, IL 61201, and that such refusal or revocation will not affect the commencement, continuation, or quality of my treatment. I understand that the revocation will not apply to information that has already been released in response to this authorization. This Authorization will remain in effect until the term of this Authorization specified herein expires or I provide a written notice of revocation for this Authorization.
- I understand that Quad City Orthodontics, LLC may not condition my treatment on whether I sign this authorization.
- I understand that if my protected health information is disclosed to someone who is not required to comply with the federal HIPAA regulations, then such information may be re-disclosed by the recipient and may no longer be protected by HIPAA.

I authorize the disclosure described herein. I have read and understand this authorization. I am the patient listed on this authorization or am authorized to act on behalf of the patient as the patient's personal representative. **I hereby release Quad City Orthodontics, LLC, from all legal responsibility of liability that may arise from the act I have authorized above.** I understand copying fees may apply and agree to pay such cost on receipt.

ATTENTION: Once the above information has been released pursuant to this Authorization, it may no longer be protected by Federal and/or State laws or regulations; and may no longer be deemed "Confidential". I consent that an image of my family, who enters the office, may be included in a photo for marketing purposes, names and/or other confidential details will not be shared on any marketing material without formal verbal and a separate written consent.

Signature of Patient or Legal Guardian:_____Date:_____

Patient Name:_____ SS#_____

Address:_____ City:_____State:_____ Zip:_____

DOB:_____ Phone:_____

Printed Name of Patient or Legal Guardian:_____

PER REQUEST: PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION