Medical & Dental History

ADULT

Please complete this form with as much detail as possible.
This confidential information will become a part of our patient records.

Patient Information

Today's Date _____ ☐ Male ☐ Female

Birthdate _____ Age _____

Full Legal Name _____ Preferred Name _____

Residence _____
Street City State Zip

Mailing Address (if different) _____

How long have you been at this address? _____

Home Phone _____ Work Phone _____

Cell Phone _____ E-Mail Address _____

Employer _____ Number of years employed _____
(Name of business if Self Employed)

Occupation _____ Social Security Number _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name _____

Whom may we thank for referring you to our office? _____

Names and ages of children: _____

Dental Insurance Information

Primary Insurance: Subscriber's Name _____
Relationship to Patient
Employer _____ Insurance Name _____

Secondary Insurance: Subscriber's Name _____
Relationship to Patient
Employer _____ Insurance Name _____

Please allow us to make copies of your insurance cards

Emergency Information

Name of nearest relative not living with you _____

Relationship _____ **Phone** _____

Address _____

PLEASE COMPLETE BOTH SIDES AND FEEL FREE TO ASK ANY QUESTIONS

DOWNEY ORTHODONTICS
Dr. Nathan M. Downey
Specialist in Orthodontics
for Children, Teens and Adults
419-352-8453
www.downeybraces.com

Rev. 3-2013

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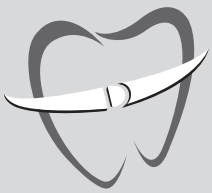

DOWNEY ORTHODONTICS

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Dental History

Dentist: _____ Date of last exam: _____

Have you been to an orthodontist before? ☐ Yes ☐ No

Have other family members had orthodontic treatment? ☐ Yes ☐ No

Is there dental work or gum treatment needed or in progress? ☐ Yes ☐ No

What are your main concerns about your teeth? _____

Yes	No		Yes	No	
☐	☐	Have you had any injuries to the face, mouth, or teeth?	☐	☐	Do you have chronic headaches?
☐	☐	Do you have any "gum" problems (periodontal disease)?	☐	☐	Do you have pain when opening or closing mouth?
☐	☐	Have you been informed of any missing or extra teeth?	☐	☐	Have you had a negative reaction to dental or medical care?
☐	☐	Do you clench or grind your teeth?			

Medical History

Medical Doctor _____ Date of last exam: _____

Under care of doctor now? ☐ Yes ☐ No Phone Number: _____

Medications being taken now: _____

Have you experienced:

Yes	No		Yes	No	
☐	☐	Blood Disorders	☐	☐	Hearing Impairment
☐	☐	Drug Allergies	☐	☐	Hepatitis
☐	☐	Allergies to latex/metals	☐	☐	HIV / AIDS
☐	☐	Allergies to plastic	☐	☐	Kidney/Liver Problems
☐	☐	Any operations	☐	☐	Rheumatic/Scarlet Fever
☐	☐	Asthma	☐	☐	Tuberculosis
☐	☐	Cancer	☐	☐	Congenital Heart Defect
☐	☐	Convulsions/Epilepsy	☐	☐	Heart Murmur
☐	☐	Diabetes	☐	☐	Heart Problems

Are there any medical conditions not listed above that you feel we need to be aware of? _____

_____

Is antibiotic premedication required before dental procedures? ☐ Yes ☐ No

Please discuss any medical problems you have that might have an effect on treatment in our office: _____

_____

Are you pregnant? (women) ☐ Yes ☐ No

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize Downey Orthodontics to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

_____ _____ _____

Signature Print Name Date

Our Office is HIPPA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Thank you for the trust and confidence you've placed in me to take care of your orthodontic needs.

- Nathan M. Downey, DDS, MS