Adult Health History Form

Dr. Brian Jacobus, Jr.
376 SW Prima Vista Blvd • Port St. Lucie, FL 34983
772-340-0023

1. About You

Today's Date: ______________________

Name: ______________________
LAST FIRST MI

I prefer to be called: __________ ☐ Male ☐ Female

Birthdate: ___/___/___ Age: _____ SS #: __________

Home Address: ______________________
APT / CONDO #

____
CITY STATE ZIP

☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Separated

Home #: (   ) __________ Cell #: (   ) __________

Work #: (   ) __________ Ext.: _____

Email: ______________________

Employer: ______________________

Occupation: __________ How long there? _____

Where & when are the best times to reach you? __________

____

____

Whom may we Thank for referring you? __________

____

Other family members seen by us: __________

____

General Dentist: ______________________

Last Visit Date: ______________________

2. Spouse Information

His / Her Name: ______________________

Employer: ______________________

Work #: (   ) __________ Ext.: _____ SS #: __________

Birthdate: ___/___/___

3. Orthodontic Insurance

Primary

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: ______________________

Insurance Co. Address: ______________________

____

Insurance Co. Phone #: (   ) __________

Group # (Plan, Local, or Policy #): __________

Insured's Name: ______________________

Relationship to Patient: ______________________

Insured's Birthdate: ___/___/___ SS #: __________

Insured's Employer: ______________________

Secondary

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: ______________________

Insurance Co. Address: ______________________

____

Insurance Co. Phone #: (   ) __________

Group # (Plan, Local, or Policy #): __________

Insured's Name: ______________________

Relationship to Patient: ______________________

Insured's Birthdate: ___/___/___ SS #: __________

Insured's Employer: ______________________

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: __________ Relation: __________

Work #: (   ) __________ Home #: (   ) __________

4. Medical History

Do you have a personal Physician? ☐ Yes ☐ No

Physician Name: ______________________

Phone #: (   ) __________ Date of last visit: __________

(continued...)

4. Medical History (continued)

Your current physical health is:
☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician?
☐ Yes ☐ No

Please explain: ____________________

Are you taking any prescription / over-the-counter drugs?
☐ Yes ☐ No

Please list each one: ____________________

For Women: Are you taking birth control pills?
☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Week #: ____________

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical conditions?

Y	N	Abnormal Bleeding	Y	N	Hemophilia
Y	N	Heart Surgery/Pacemaker	Y	N	Asthma/Arthritis
Y	N	Anemia/Radiation Treatment	Y	N	Hepatitis
Y	N	Artificial Bones/Joints/Valves	Y	N	Blood Transfusion
Y	N	High/Low Blood Pressure	Y	N	HIV+/AIDS
Y	N	Hospitalized for Any Reason	Y	N	Cancer/Chemotherapy
Y	N	Severe/Frequent Headaches	Y	N	Congenital Heart Defect
Y	N	Diabetes/Tuberculosis (TB)	Y	N	Kidney Problems
Y	N	Rheumatic/Scarlet Fever	Y	N	Mitral Valve Prolapse
Y	N	Epilepsy/Seizures/Fainting	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Drug/Alcohol Abuse
Y	N	Emphysema/Glaucoma	Y	N	Shingles
Y	N	Fever Blisters/Herpes	Y	N	Sinus Problem
Y	N	Heart Attack/Stroke	Y	N	Ulcers/Colitis
Y	N	Heart Murmur	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Dental Anesthetics	Y	N	Penicillin
Y	N	Latex	Y	N	Any Metals/Plastics	Y	N	Tetracycline
Y	N	Codeine	Y	N	Erythromycin	Y	N	Other

Please list any other drugs / materials that you are allergic to:

____

5. Dental History

What are the main concerns that you would like orthodontic treatment to address?

____

____

Have you ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work?
☐ Yes ☐ No

Have you ever had any pain / tenderness in your jaw joint (TMJ / TMD)?
☐ Yes ☐ No

Your current dental health is:
☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had an injury to your:
☐ Mouth ☐ Teeth ☐ Chin

Do you have any speech problems?
☐ Yes ☐ No

Do you generally breathe through your mouth?
☐ Yes ☐ No

If yes: ☐ While Awake
☐ While Asleep

Do you have any missing or extra permanent teeth?
☐ Yes ☐ No

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

____
Signature of patient Date

This office reserves the right to verify the credit status of potential patients and / or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

____
Signature of patient Date

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

____
Signature of patient Date

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

Office Use Only

I verbally viewed the medical information with the parent/guardian and patient named herein.

Doctor's Comments:____________________Initials: ________ Date: ________

____