Conlon & Thompson Orthodontics, Ltd.

DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

SPECIALISTS IN ORTHODONTICS FOR CHILDREN & ADULTS

Members American Association of Orthodontists

815.344.2840 Fax 815.344.2859

HEALTH HISTORY (For Adults)

ABOUT YOU

Name: _____ I prefer to be called: _____
LAST FIRST MIDDLE

Age: _____ Sex: _____ Birthday: _____ Soc. Sec. #: _____

Home Address: _____
STREET CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

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

Names of other family members treated by our office: _____

_____

Employer: _____ Occupation: _____ # Years: _____

Employer's Address: _____

Spouse's Name _____

Employer: _____ Occupation: _____ # Years: _____

Soc. Sec. #: _____ Birthdate: _____ Work Phone: _____

Person Responsible for Account **(if different from above):**

Their Name: _____ Soc. Sec. # _____

Address: _____

Home Phone: _____ Work Phone: _____

Employer: _____

DENTAL INSURANCE

Primary Insured's Name: _____ ID #: _____

Primary Insur. Co.: _____ Group #: _____ DOB: _____

Insurance Co. Address: _____ Phone No. 1-800-_____

Do you have dual coverage? ☐Yes ☐No (If yes, birthdates of each insured must be provided above)

Secondary Insured's Name: _____ Soc. Sec. #: _____

Secondary Insur. Co.: _____ Group #: _____ DOB: _____

Insurance Co. Address: _____ Phone No. _____

Your signature below authorizes assignment of insurance benefits

Signature: _____ Date: _____

Updates (date and initial) _____ _____ _____

(please complete other side)

DENTAL HISTORY

Date of last dental check-up: _____

Name and address of your dentist: _____

Have you been treated for periodontal disease? ☐Yes ☐No
(gum disease, pyorrhea, trench mouth)

Have there been any injuries to the face, mouth or teeth? ☐Yes ☐No When? _____

Do you grind your teeth? ☐Yes ☐No

☐ While asleep ☐ During the day

Do you suffer from regular headaches, jaw aches (TMJ) or facial pain? ☐Yes ☐No

If so, when does it hurt?

How often does it occur? ☐daily ☐ weekly ☐monthly ☐only on occasion

☐Other _____

Have you received treatment for this condition? ☐Yes ☐No

Are you still undergoing treatment: ☐Yes ☐No By whom? _____

Have you previously had an orthodontic consultation or orthodontic treatment? (circle) Yes No

If yes, when and by whom? _____

Please give your reasons for having an orthdontic consultation _____

_____

MEDICAL HISTORY

Date of last physical exam: _____

Name and address of your physician: _____

Do you have or have you had any of the following. Please indicate with a check mark (✓).

☐ Any heart problems
☐ High blood pressure
☐ Low blood pressure
☐ Circulatory problems
☐ Nervous problems
☐ Radiation treatments
☐ Excessive bleeding
☐ AIDS/HIV positive
☐ Other _____

☐ Allergies to anesthetics
☐ Allergies to medicines/drugs
_____
☐ Allergies to
_____
☐ Anemia
☐ Arthritis
☐ Asthma

☐ Diabetes
☐ Hepatitis
☐ Herpes
☐ Malignancies
☐ Measles
☐ Mumps
☐ Psychiatric care
☐ Rheumatic Fever

☐ Scarlet Fever
☐ Sinus Problems
☐ Stroke
☐ Typhoid Fever
☐ Tonsilitis
☐ Tuberculosis
☐ Ulcer
☐ Venereal Disease
☐ Chronic headaches

Are you presently taking or have you ever taken any cancer medications or medications for osteoporosis?

☐Yes ☐No If yes, please list drugs and dates: _____

Are you required to premedicate prior to dental visits? _____

Are you pregnant? ☐Yes ☐No

Please indicate any medication(s) that you are presently taking _____

_____

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment. _____

Signature _____ Date _____

GENERAL INFORMATION

Name and ages of children _____

How do you like to spend your free time? _____

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