ADULT MEDICAL HISTORY

Today's date: _____ /_____ /_____

Whom can we thank for referring you to our office?

_____

Y / N….. Any family members/friends treated in our office?

Patient's Last Name: _____

First Name: _____ M.I.: _____

Date of Birth: _____ / _____ / _____ Age: _____

Male: ____ Female: ____

Height: _____ Weight: _____

Social Security #: _____-_____-_____

Driver's License #: _____

Address:

_____

_____

City: _____ St.: _____ Zip: _____

How long have you resided at this address? _____

Home Phone: (_____) - _____-_____

Cell Phone: (_____) - _____ -_____

Email: _____

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

Sports/Hobbies:

_____

_____

Y / N….. Do you play any Musical Instrument?

_____

What is your primary concern/what would you like the orthodontist to address or evaluate today?

_____

_____

_____

Y / N….. Have you ever been treated or evaluated by an orthodontist before?

Dental Insurance Information:

Insurance Company Name: _____

Insurance Co. Phone Number: (_____) - _____-_____

Policy Holder: _____

Policy Holder D.O.B.: _____ / _____ / _____

I.D. #: _____

Social Security #: _____

Group #: _____

Employer: _____

Job Title: _____

How long with current employer: _____

General Dentist Information:

Name of Dentist: _____

Phone Number: (_____) - _____-_____

Date of last Visit: _____

Reason: _____

Physician information:

Name of Physician: _____

Phone Number: (_____) - _____-_____

Relative/Spouse Information:

Name: _____

Address: _____

_____

City: _____ St.: _____ Zip: _____

Home Phone: (_____) - _____-_____

Cell Phone: (_____) - _____ -_____

Work Phone: (_____) - _____ -_____

For the following questions please circle Y (Yes), N (No), or DK/U (Don't know or understand). The answers you provide are for office records <u>only</u> and will be considered confidential.

Keep in mind, a thorough and complete history is vital for a proper orthodontic evaluation.

Y….N….DK/U…. Birth defects or hereditary problems

Y….N….DK/U…. Bone fracture or any major accidents

_____

Y….N….DK/U…. Rheumatoid or arthritic conditions

Y….N….DK/U…. Endocrine or thyroid problems

Y….N….DK/U…. Kidney problems

Y….N….DK/U…. Hepatitis, jaundice, or liver problems

Y….N….DK/U…. AIDS/HIV+

Y….N….DK/U…. STD's (Sexually Transmitted Diseases)

Y….N….DK/U…. Fainting spells, seizures, epilepsy or neurologic disease

Y….N….DK/U…. Mental health or behavioral problems

Y….N….DK/U…. Diabetes

Y….N….DK/U…. Cancer or tumor treatment

Y….N….DK/U…. Stomach ulcer or hyperacidity

Y….N….DK/U…. Polio, mononucleosis, tuberculosis

Y….N….DK/U…. Chest pain, shortness of breath, ankle swelling

Y….N….DK/U…. Cardiovascular problems (Heart trouble)

Y….N….DK/U…. Heart attack, angina, coronary insufficiency

Y….N….DK/U…. Skin disorder

Y….N….DK/U…. Do you have a normal/good diet?

Y….N….DK/U…. Have you recently been under another dentist's care?

Y….N….DK/U…. Frequent headaches, colds, sore throat

Y….N….DK/U…. Eye, ear, throat condition

Y….N….DK/U…. Tonsil or adenoid condition

Y….N….DK/U…. Allergies or drug reactions (please list)

_____

_____

Y….N….DK/U…. Are you taking medication, nutrient supplements, or non-prescription drugs?

_____

_____

Y….N….DK/U…. Do you currently have or have you ever had a substance abuse problem

Y….N….DK/U…. Operations

_____

_____

Y….N….DK/U…. Hospitalizations

_____

_____

Y….N….DK/U…. Other physical problems or symptoms

_____

_____

Y….N….DK/U…. Are you being treated by another healthcare professional?

Y….N….DK/U…. Are you in good health?

Date of most recent physical: _____/_____/_____

Y….N….DK/U…. Any recent weight loss or poor appetite

Y….N….DK/U…. Excessive bleeding, black and blue tendency, or anemia

Y….N….DK/U…. High or low blood pressure

Y….N….DK/U…. Easily tired

<u>Female Patients:</u>

Y….N….DK/U…. Are you pregnant?

Y….N….DK/U…. Are you taking birth control?

Y….N….DK/U…. Are you anticipating becoming pregnant?

Dental History:

Y….N….DK/U…. History of supernumerary (extra) teeth or congenitally missing teeth

Y….N….DK/U…. Permanent teeth removed

Y….N….DK/U…. Aware of loose, broken or missing restorations (fillings)

Y….N….DK/U…. Any teeth irritating cheek, lip, tongue or palate

Y….N….DK/U…. Have you had periodontal (gum) disease?

Y….N….DK/U…. History of speech problems

Y….N….DK/U…. Hay fever, asthma, sinus trouble or hives

Y….N….DK/U…. Do you have any concerns regarding crooked, spaced, or protruding teeth?

Y….N….DK/U…. Are you aware or concerned about an under or over developed jaw?

Y….N….DK/U…. Do you have any relatives with similar tooth or jaw relationships?

Y….N….DK/U…. Problems with wisdom teeth

Y….N….DK/U…. Have you had any serious trouble associated with any previous dental treatment?

Y….N….DK/U…. Chipped or otherwise injured permanent teeth

Y….N….DK/U…. Teeth sensitive to hot or cold

Y….N….DK/U…. Jaw fractures, cysts, or mouth infections

Y….N….DK/U…. "Dead teeth" or root canals treated

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

Y….N….DK/U…. Periodontal (gum) problems

Y….N….DK/U…. Food impactions between teeth

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

Y….N….DK/U…. Thumb, finger or sucking habit

Y….N….DK/U…. Mouth breathing or tongue thrusting

Y….N….DK/U…. Any pain in jaw or ringing ears

Y….N….DK/U…. Have you ever been treated for TMJ problems?

Y….N….DK/U…. Do you encounter difficulty in chewing or jaw opening/closing?

Y….N….DK/U…. Abnormal swallowing habits

Y….N….DK/U…. Do you experience any pain or soreness in the muscles of your face or around the ears?

How often do you brush? _____

How often do you floss? _____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene. Are there any restrictions, handicaps or problems that might be encountered during treatment?

_____
_____
_____
_____

I understand the information I have given is true and correct to the best of my knowledge, it will be held at the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in this form.

I understand Credit Bureau information may be obtained for office payment plans.

X _____

Patient Signature **Date: _____/_____/_____**

Agreement to Receive Electronic Communication

Patient Name: _____**Date of Birth:** _____

I agree that the dental practice may communicate with me electronically at the email address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling: 954-452-9988 OR info@jacarandasmiles.com

Patient/ Legal Guardian Signature: _____ **Date:** _____

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Name: _____
Signature: _____
Date: _____

FOR OFFICIAL USE ONLY

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify): _____

ABOUT ICAT CBCT CONE BEAM SCANS

Jacaranda Orthodontics and Pediatric Dentistry now offers an exciting new technology for our patients and for patients of other doctors who might be referred here. This technology is called I-Cat Cone Beam Computer Assembled Tomography (CBCT) imaging, sometimes called 3-D radiographs or x-rays. Using CBCT means we now have the ability to take 3D images of the teeth, jaws, bones and facial structures at lower costs and with less energy than a typical CT scan used in hospitals. 3D imaging provides us the opportunity of improved diagnosis for our patients, especially in cases of impacted teeth, dental implants, surgical treatment, as well as more complex cases. Understandably you may have questions about exposure to these types of x-rays. Here are some facts you should know about 3-D imaging.

An ICAT CBCT exposure is:

- About 1/2 as much as a full series of digital dental images
- About 1/5 as much as a full (28) mouth series of standard dental x-rays
- About 1/70 as much as a typical medical CT scan

CBCT therefore offers our patients enhanced diagnostic value at a significantly reduced exposure. At the same time, CBCT scans can image the entire head and most of the neck. As dentists and orthodontists, we evaluate teeth, jaws and surrounding supporting bone, using CBCT's for those limited purposes.

Our training and dental license does not provide for evaluating and diagnosing outside those areas. However since CBCT imaging can cover a broader area, we want to offer you the opportunity to have your CBCT scan read by an oral radiologist, trained and licensed to evaluate and diagnose a broader area. CBCT may show evidence of disease of the cervical spine, skull or arteries. We can refer you to a radiology group for this purpose. The average cost is about $ $195.00. If you are interested in taking advantage of this service please initial the application section and sign the acknowledgement below.

( ) YES, I want to have my I-Cat CBCT scans read by an oral radiologist and understand I am responsible for the additional costs.

( ) NO, I understand the risks and benefits of having my CBCT read and interpreted by an oral radiologist, however I knowingly decline such a referral.

X_____ _____/_____/_____

Signature of patient/responsible party **Date**