



PATIENT ID # _____

We are pleased to welcome you to our office. Please fill out this form as completely as you can.
We look forward to a pleasant and professional relationship with you.

ADULT PATIENT HISTORY FORM

Date _____

PATIENT INFORMATION

Last Name _____ First _____ Middle _____

Nickname _____ Birthdate _____ Age _____

Gender: MALE FEMALE Marital Status: Married Single Divorced

Home Address: Street _____ City _____ State _____ Zip _____

Phone: Mobile _____ Home _____ Work _____

Email _____ SSN # _____

Employer _____ Occupation _____

Business Address: Street _____ City _____ State _____ Zip _____

SPOUSE INFORMATION

Last Name _____ First _____ Middle _____

Birthdate _____ Age _____ SSN # _____

Home Address: Street _____ City _____ State _____ Zip _____

Phone: Mobile _____ Home _____ Work _____

Email _____

Employer _____ Occupation _____

Business Address: Street _____ City _____ State _____ Zip _____

GENERAL INFORMATION

How did you hear about our office? dentist family friend online other _____

If referred by someone, whom may we thank? _____

Which office is more convenient for you? Ala Moana Kunia

ORTHODONTIC INSURANCE INFORMATION

PRIMARY INSURANCE

SECONDARY INSURANCE

Name of insured _____

Name of insured _____

Name of insurance _____

Name of insurance _____

Group # _____

Group # _____

Subscriber # _____

Subscriber # _____

Effective date _____

Effective date _____

Patient Signature _____ Date _____

PATIENT MEDICAL HISTORY

Physician _____ Phone # _____ Date of last exam _____

Physician Address: Street _____ City _____ State _____ Zip _____

Emergency Contact _____ Relationship _____ Phone # _____

Do you have, or have you had any of the following:

- | | | |
|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Fainting spells / Seizures |
| <input type="checkbox"/> Heart Ailments | <input type="checkbox"/> Blood Diseases | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis, Jaundice | <input type="checkbox"/> Rheumatism / Arthritis |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Head Injuries |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney / Liver Disease | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors or Growths | <input type="checkbox"/> Tonsils removed |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tonsils / Adenoids removed | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Allergies (latex / metal) | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Asthma or Hay Fever | <input type="checkbox"/> Disabilities |
| <input type="checkbox"/> Bone disorder or bone loss | <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Pregnant (Women) |

- Have you ever been hospitalized or had a serious illness? Yes No _____
- Do you use tobacco, alcohol, cocaine or other drugs? Yes No _____
- Are you under a physician's care now? Yes No _____
- Are you sensitive or allergic to any drugs? Please list. Yes No _____
- Are you taking any medications or vitamins? Please list. Yes No _____

PATIENT DENTAL HISTORY

Dentist _____ Phone # _____ Date of last exam _____

Dentist Address: Street _____ City _____ State _____ Zip _____

- Have you ever been treated for periodontal (gum) disease? Yes No _____
- Have you ever had complications from dental extractions? Yes No _____
- Do your gums bleed excessively? Yes No _____
- Do you have cold sores, blisters or swelling on gums/lips/cheeks? Yes No _____
- Do you suffer from headaches? If yes, how often? Yes No _____
- Any difficulty breathing through your nose or difficulty swallowing? Yes No _____
- Any pain or clicking in your jaw joint? Yes No _____
- Are you aware of clenching or grinding of your teeth? Yes No _____
- Do you have any speech problems? Yes No _____
- Any accidents to your jaws, face or teeth? Yes No _____
- Have you had previous orthodontic treatment? If so, with whom? Yes No _____
- Has anyone else in your family had orthodontic treatment? Yes No _____
- If yes, please list: _____

What is the patient's main orthodontic concern? _____

Is there anything else in your dental/medical history we need to know when considering your treatment?

I, the undersigned, believe the above information to be complete and accurate. If there are any changes to this history in the future I will inform the Hawaii Orthodontist office.

Patient Signature _____ Date _____

Form Updates _____	Office Initial _____	Date _____
Form Updates _____	Office Initial _____	Date _____
Form Updates _____	Office Initial _____	Date _____