

# A. Paul Serrano, DDS PC, Delbert L. Kyger, DDS, MS Patient Information & Medical History - Adult



Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Birthday: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Bus Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Occupation: \_\_\_\_\_ Patient is:  Married  Single  Divorced  Widowed  Separated

MD: \_\_\_\_\_ Phone: \_\_\_\_\_ Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Financially Responsible Party: \_\_\_\_\_ Relationship: \_\_\_\_\_

Birthday: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

Bus. Phone: ( ) \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Employed Since: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ Ext: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Birthday: \_\_\_\_\_

Employer: \_\_\_\_\_ Position: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Insurance Primary Carrier: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Policy # \_\_\_\_\_ Insured's Name: \_\_\_\_\_ I.D. # \_\_\_\_\_

Secondary Carrier: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

Policy # \_\_\_\_\_ Insured's Name: \_\_\_\_\_ I.D. # \_\_\_\_\_

Other Family Members Treated: \_\_\_\_\_

Musical Instrument Played: \_\_\_\_\_ Favorite Sports & Hobbies: \_\_\_\_\_

In Case We Cannot Reach You / Person To Contact: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default. I further understand that if a payment becomes 45 days past due, a \$5.00 late fee will be assessed on delinquent amounts from the date the payment was due. I hereby authorize the release of medical information if necessary, and payments from the above mentioned Insurance company to go directly to Dr. A. Paul Serrano. I also understand that I am responsible for any balance that my insurance company does not pay for. I am aware that when appropriate, this office requests credit history information.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date

For the following questions circle yes, no, or don't know / understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

## MEDICAL HISTORY

- |     |    |      |  |     |    |      |   |
|-----|----|------|--|-----|----|------|---|
| yes | no | dk/u | Birth defects or hereditary problems?          | yes | no | dk/u | Hepatitis, jaundice or liver problem?                                     |
| yes | no | dk/u | Bone fractures, any major accidents?           | yes | no | dk/u | AIDS or HIV Positive?   |
| yes | no | dk/u | Rheumatoid or arthritic conditions?            | yes | no | dk/u | Sexually transmitted disease?   |
| yes | no | dk/u | Endocrine or thyroid problems?                 | yes | no | dk/u | Fainting spells, seizures, epilepsy or neurologic disease.                |
| yes | no | dk/u | Kidney problems?                               | yes | no | dk/u | Mental health or behavioral problems?                                     |
| yes | no | dk/u | Diabetes?                                      | yes | no | dk/u | Vision, hearing, tasting or speech difficulties?                          |
| yes | no | dk/u | Cancer or been treated for a tumor?            | yes | no | dk/u | Loss of weight recently, poor appetite?                                   |
| yes | no | dk/u | Stomach ulcer or hyperacidity?                 | yes | no | dk/u | Excessive bleeding, black and blue tendency, anemia or bleeding disorder? |
| yes | no | dk/u | Polio, mononucleosis, tuberculosis, pneumonia? | yes | no | dk/u | High or low blood pressure?   |
| yes | no | dk/u | Problems of the immune system?                 | yes | no | dk/u | Easily tired?   |

yes no dk/u Any history of antibiotics prior to dental appointments?  
 yes no dk/u Chest pain, shortness of breath or swelling ankles?  
 yes no dk/u Cardiovascular problems (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects or rheumatic heart?  
 yes no dk/u Skin disorder  
 yes no dk/u Do you have a normal and good diet?  
 yes no dk/u Frequent headaches, colds or sore throats?  
 yes no dk/u Any history of speech problems?  
 yes no dk/u Eye, ear, nose, throat condition?  
 yes no dk/u Hayfever, asthma, sinus trouble, hives?  
 yes no dk/u Tonsil or adenoid conditions?  
 yes no dk/u Allergies?  
 yes no dk/u Drug reactions?  
 yes no dk/u Are you taking medication, nutrient supplements or prescription medicine? Please name them.

yes no dk/u Do you have osteoporosis?  
 yes no dk/u Do you currently have or ever had substance abuse problems?  
 yes no dk/u Operations?  
 yes no dk/u Hospitalized? For \_\_\_\_\_  
 yes no dk/u Other physical problems or symptoms?  
 yes no dk/u Being treated by another health care professional? For \_\_\_\_\_  
 yes no dk/u Are you in good health?  
 Date of most recent physical exam? \_\_\_\_\_

**FEMALE PATIENT**

yes no dk/u Are you pregnant?  
 yes no dk/u Are you taking birth control pills?  
 yes no dk/u Are you anticipating becoming pregnant?

**DENTAL HISTORY**

yes no dk/u Chipped or otherwise injured permanent teeth?  
 yes no dk/u Teeth sensitive to hot or cold; teeth throb or ache?  
 yes no dk/u Jaw fractures, cysts, mouth infections?  
 yes no dk/u "Dead Teeth", root canals, mouth odor?  
 yes no dk/u Bleeding gums, bad taste, mouth odor?  
 yes no dk/u Periodontal "Gum Problems"?  
 yes no dk/u Food impaction between teeth?  
 yes no dk/u "Gum Boils" frequent canker sores, cold sores?  
 yes no dk/u Thumb, finger, sucking habit? (tongue thrusting)?  
 yes no dk/u Abnormal swallowing habit (tongue thrusting)?  
 yes no dk/u Mouth breathing habit, snoring, difficulty in breathing.  
 yes no dk/u Tooth grinding, jaw clenching, clicking, locking?  
 yes no dk/u Do you experience any pain or soreness in the muscles of your face, or around the ears?  
 yes no dk/u Any pain in jaw or ringing in the ears?  
 yes no dk/u Difficulty encountered in chewing or jaw opening?

yes no dk/u History of supernumerary (extra) or congenitally missing teeth?  
 yes no dk/u Have any permanent teeth been removed?  
 yes no dk/u Aware of loose, broken or missing restorations (fillings)?  
 yes no dk/u Any teeth irritating cheek, lip, tongue, palate?  
 yes no dk/u Have you ever had Orthodontic treatment or worn a "retainer" or "bite plate"?  
 yes no dk/u Have you recently been under another dentist's care?  
 Specialist \_\_\_\_\_  
 yes no dk/u Have you ever had Periodontal (gum) treatment?  
 yes no dk/u Concerned about spaced, crooked, protruding teeth?  
 yes no dk/u Aware or concerned about under or over developed jaw.  
 yes no dk/u Any relative with similar tooth or jaw relationships?  
 yes no dk/u Any wisdom tooth problems?  
 yes no dk/u Have you had any serious trouble associated with any previous dental treatment?

Present Weight \_\_\_\_\_ Height \_\_\_\_\_

What is your primary concern? – Why are you here? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date of most recent dental examination \_\_\_\_\_  
 How often do you brush \_\_\_\_\_ 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 have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical / dental status, I will so inform this practice.  
 \_\_\_\_\_

Signature of patient \_\_\_\_\_ Date \_\_\_\_\_

Medical History Update or Changes: Date: Comments: Signature  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
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