HEALTH HISTORY FORM

PATIENT INFORMATION *(This information is necessary for our files & will be considered CONFIDENTIAL)*

ALPAN ORTHODONTICS
Dr. David Alpan and Associates

Patient's Name _____ Patient's Birthday _____ ☐Minor ☐Male ☐Female

Age _____ Relationship to Patient _____ Patient is: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

If the patient is a minor, please provide the name of the parent or legal guardian. _____ Email _____

Resident Address _____ How long? _____ ☐Own ☐Rent Phone _____

Cell Phone _____ Driver's License No. _____ Social Security No. _____ Occupation _____

How long? _____ Employer _____ Business Phone _____ Business Address _____

Nearest Relative Not Living Near You _____ Address _____ Phone _____

Physician Name _____ ☐I have none Address _____ Phone _____

Dentist/Orthodontist _____ ☐I have none Address _____ Phone _____

Children's School _____ Is this visit for Emergency Orthodontic Care? ☐Yes ☐No

What is your main concern about your smile, bite or teeth? _____

Expectations for this appointment? _____ Whom may we thank for referring you? _____

FINANCIAL INFORMATION

Person Responsible for this Account _____ Relationship _____

Cell Phone _____ Phone _____ Address _____

Primary Insurance Company _____ Insured Person's Name _____

Social Security No. _____ Birthday _____ Relationship _____ Group Dental Plan _____

Group No. _____ Plan No. _____ Union Name _____ Local _____

Secondary Insurance Company _____ Insured Person's Name _____

Social Security No. _____ Birthday _____ Relationship _____ Group Dental Plan _____

Group No. _____ Plan No. _____ Union Name _____ Local _____

TERMS AND CONDITIONS As a condition of treatment by this office, I understand financial arrangements must be made in advance. The office requires reimbursement from the patients for the costs incurred in their care, & financial responsibility on the part of each patient must be determined before treatment. All emergency orthodontic services, or any orthodontic service performed without prior financial arrangements, must be paid for in cash at the time services are performed. I understand that orthodontic services furnished to me are charged directly to me & that I am personally responsible for payment of all orthodontic services. I carry insurance & I understand that this office will help prepare my insurance forms to assist in making collections from my insurance companies & will credit such collections to my account. However, AO cannot render services on the assumption that charges will be paid by an insurance company. All fees & charges are the responsibility of the patient or responsible party.

ASSIGNMENT OF INSURANCE: I hereby authorize my insurance company to pay directly to my Orthodontist the benefits accruing to me under my policy. **A monthly administrative fee of $50** may be applied to any outstanding balance not paid within 30 days. I understand that the fee estimate listed for this orthodontic service can only be extended for a period of six months from the date of the patient's examination. In consideration of the professional services rendered to me, or at my request, by the Doctor and/or by the staff, I agree to pay the reasonable value of said services to said Doctor, or any assignee, at the time said services are rendered. I furthermore agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time of paying thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that if either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred, including reasonable attorney's and/or collection fees.

☐I have read the above conditions of treatment and agree to their content. Signature _____ Date _____

HEALTH QUESTIONNAIRE These questions are for your benefit and ensure that treatment will take into consideration your past & present health status. Some questions may seem unrelated to your orthodontic condition, but they are all associated with proper oral health care. Please answer each question. Check the appropriate box and/or circle **YES or No** where applicable.

MEDICAL HISTORY Are you in good health? ☐Yes ☐No Date of last physical examination _____

Are you now under the care of a physician? ☐Yes ☐No If so, what is the condition being treated? _____

Have you had any serious illness or operation? ☐Yes ☐No If so, what illness or operation? _____

Have you ever been hospitalized? ☐Yes ☐No If so, what was the problem? _____

Are you taking any: ☐Medication ☐Drugs ☐Herbs If so, what? _____ Dosage? _____

Are you using any recreational drugs (marijuana, cocaine, etc.)? ☐Yes ☐No If so, what? _____

Have you ever been pre-medicated with antibiotics for your dental treatment? ☐Yes ☐No If so, what? _____

Are you sensitive or allergic to any drugs or materials? ☐Yes ☐No ☐Penicillin ☐Tetracycline ☐Sulfa Drugs ☐Aspirin ☐Codeine ☐Latex ☐Other _____

Do you smoke? ☐Yes ☐No ☐Cigarettes ☐Cigars ☐Packs per day

If so, how much? _____

Have you ever taken these drugs? ☐Yes ☐No ☐Fen-phen ☐Redux

☐Zometa ☐Actonel ☐Boniva ☐Fosamax (Bisphosphonate) ☐Diet Drugs

WOMEN Are you pregnant? ☐Yes ☐No If so, how many months? _____

Do you have any problems associated with your menstrual period? ☐Yes ☐No

Do you take any birth control medication and hormones? ☐Yes ☐No

Do you have children? ☐Yes ☐No If so, how many? _____

DISEASE, CONDITION, OR PROBLEM

☐Hay Fever	☐Kidney Disease	☐Emphysema	☐Cortisone Medicine	☐Mental Disorder	☐Difficulty Sleeping
☐Seizures	☐Drug Addiction	☐Cold Sores	☐Sickle Cell Disease	☐Angina Pectoris	☐Sleep Issues
☐Cancer	☐Cerebral Palsy	☐Hemophilia	☐Artificial Prosthesis	☐Epilepsy or Seizures	☐Difficulty Chewing
☐Asthma	☐Heart Attack	☐Tonsillitis	☐Pain in Jaw Joints	☐Psychiatric Treatment	☐Difficulty Eating
☐Arthritis	☐Heart Ailments	☐Glaucoma	☐Allergies or Hives	☐Hepatitis or Jaundice	
☐Diabetes	☐Blood Disease	☐Implant(s)	☐Tumors or Growths	☐Difficulty Swallowing	
☐Ulcers	☐Heart Murmur	☐Headaches	☐Nervous Disorders	☐Congenital Heart Disease	
☐Stroke	☐Sinus Trouble	☐Respiratory Disease	☐Joint Replacement	☐Osteoporosis	
☐Herpes	☐Scarlet Fever	☐HIV-Related Complex	☐Low Blood Sugar	☐X-Ray or Cobalt Treatment	
☐Anemia	☐Heart Failure	☐Low Blood Pressure	☐Blood Transfusion	☐Radiation Treatment (any kind)	
☐Sleep Apnea	☐Head Injuries	☐High Blood Pressure	☐Tuberculosis (T.B.)	☐Venereal Disease (Syphilis, Gonorrhea)	
☐Snoring	☐Bruise Easily	☐Mitral Valve Prolapse	☐Rheumatic Fever	☐Acquired Immune Deficiency Syndrome (AIDS)	
☐Stomach Ulcers	☐Chicken Pox	☐Excessive Bleeding	☐Fainting Spells	☐TMJ Disorder (Temporomandibular Joint Disorder)	
☐Chemotherapy	☐Rheumatism	☐Allergies to Metals	☐Thyroid Disease	☐TMJ Pain, Jaw Pain	

Do you have any disease, condition or problem not listed that you think we should know about? ☐Yes ☐No If so, what? _____

DENTAL HISTORY Have you ever been recommended orthodontic treatment? ☐Yes ☐No If so, by whom? _____

Have you ever had orthodontic treatment? ☐Yes ☐No If so, what date? _____

Have you completed all your dental work, or is there more planned for the future? ☐Yes ☐No If so, explain? _____

How long since your last full mouth x-rays? ☐Weeks_____ ☐Months_____ ☐Years_____

How long since your last cleaning with dental hygienist? ☐Weeks_____ ☐Months_____ ☐Years_____

Do you experience anxiety during dental treatment? ☐Yes ☐No If yes: ☐Mild ☐Moderate ☐Severe

Are you currently wearing any dental removable devices? ☐Yes ☐No If so, explain? _____

What is it about your smile you would like to improve? _____

☐I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way.

Patient refused / was unable to sign because: _____

☐To the best of my knowledge, all of the preceding answers are true & correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

Signature _____ Date _____

Reviewed By _____ License No. _____ Date _____

HEALTH QUESTIONNAIRE MUST BE CONTINUALLY UPDATED!

CONSENT FOR TREATMENT I hereby grant authority to the orthodontist in charge of the care of the patient whose name appears on this Health History form, to perform such procedures as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures. **All services are rendered and accepted under the terms and conditions printed on the reverse hereof: Authorization must be signed by the patient, or by the nearest relative in the case of a minor, or when the patient is physically or mentally incompetent.**

Signature _____ Date _____