ADULT HEALTH QUESTIONAIRE

(Confidential information necessary for your files and your health)

Today's Date ________________

Patient's Name (first)________________________(last)____________________**Birthdate**_____________**Age**_____**Gender** **M / F**

Home # _________________**Cell #** _________________ **Would you like to receive appointment reminders by text? Y or N**
E-mail_____________________________
Address ____**City**__________________**Postal Code**____________

Occupation ________________________ **Work #** __________________
Dentist ____ **Physician** ______________________________________

Spouse/Nearest Relative (first)__________________(last)______________**Relationship**:______________**Cell #**_____________

Address ____ **City**__________________ **PC** _____________
(if different from Patient)

Please check box

1. Are you in good health?____YES ☐ NO ☐

2. Have you previously been or are currently under the care of a health care professional for any kind of condition or syndrome?____YES ☐ NO ☐
   If Yes, please explain: ____

3. Have you ever been hospitalized or had a serious illness or accident?_______________________________YES ☐ NO ☐
   If Yes, please explain:____

4. Please list any medications you are currently taking.____

5. Please check any of these medications you may have taken in the past year:

   ☐Penicillin ☐Blood thinners ☐Digitalis Other__________
   ☐Cortisone ☐Tranquilizers ☐Thyroid
   ☐Nitroglycerin ☐Dilantin ☐Aspirin ____________________

6. Please check any of the items below that you have ever a bad reaction to:

   ☐Local Anesthetics ☐Codeine ☐Insulin ☐Barbituates ☐LATEX
   ☐ Ibuprofen Penicillin ☐Aspirin ☐Iodine ☐Metals: _______ Other____________

7. Please list any illness:
   You currently have: ____

   Have had in the past: ____

8. Do you suffer frequent colds?____YES ☐ NO ☐

9. Do you have difficulty breathing through your nose?______________________________________YES ☐ NO ☐

10. Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma?__________YES ☐ NO ☐

11. Have you **ever** (at any age) had an injury to the head, neck, face, teeth or chin? (ie. Stitches, concussions, whiplash) YES ☐ NO ☐
    If Yes, please explain ____

12. Is there any other information I should know about your health or previous dental treatment? YES ☐ NO ☐
If Yes, please explain:____

13. Are you pregnant?____ YES ☐ NO ☐

14. Do you have a metal or latex sensitivity:____ YES ☐ NO ☐

15. Have you previously or do you currently wear an appliance for jaw joint issues?____________________ YES ☐ NO ☐

16. Do you see a dentist for regular check ups/cleanings? (date of your last checkup?)____________________ YES ☐ NO ☐

17. Have you ever been told that you require antibiotics prior to dental treatment?____________________ YES ☐ NO ☐

18. Have you had a recent exposure to any communicable infectious diseases? (measles, chicken pox or Tuberculosis) YES ☐ NO ☐

19. In the last 24 hours have you had a new cough, shortness of breath, fever, chills, diarrhea or other flu-like symptoms? If yes, please explain________________________________ YES ☐ NO ☐

20. What is your main reason for seeking orthodontic care? Do you have specific questions you would like answered today?____

____

INSURANCE INFORMATION

Policy Holder Name ______________________ **(2)** ______________________

Policy Holder Birthdate ______________________ ______________________

Insurance Company ______________________ ______________________

Group/Policy ______________________ ______________________

I.D./Cert.No. ______________________ ______________________

ACCOUNTING INFORMATION

Responsible Billing Party, (if different from patient)

Name: **(first)**______________________ **(last)**______________________ **Relationship**______________________

Address:____ **PC** ______________________

Cell # ______________________

I CONFIRM THAT THE ABOVE INFORMATION IS ACCURATE AND TRUE TO THE DATE OF COMPLETION.
By signing below, you are also consenting to receive email communication from Authentic Orthodontics. This includes, but is not limited to; payment receipts, appointment reminders and occasional information about current events. IF you prefer not to receive emails from Authentic Orthodontics, please let us know.

Signature: ______________________ **Print Name:** ______________________ **Date:**______________

Authentic Orthodontics
540, 19489 Seton Cres SE Calgary, AB T3M 1T4
403-523-9101
info@authenticortho.com **www.authenticortho.com**