FOWLER ORTHODONTICS

Adult Health History Information

PATIENT'S NAME_____AGE _____
ADDRESS_____ CITY_____ZIP_____
HOME PHONE_____ CELL_____ BIRTH DATE_____
SOCIAL SECURITY # _____
EMPLOYED BY _____OCCUPATION_____
EMAIL_____

SPOUSE'S NAME _____BIRTH DATE _____ SS#_____
EMPLOYED BY _____ OCCUPATION_____
BUSINEES PHONE_____ CELL _____
EMERGENCY CONTACT _____ PHONE NUMBER_____

INSURANCE INFORMATION
PERSON FINANCIALLY RESPONSIBLE_____ PHONE _____
NAME OF INSURANCE COMPANY_____ ID # _____
SOCIAL SECURITY NUMBER _____ INSURED BIRTH DATE _____

WHO MAY WE THANK FOR REFERRING YOU? _____
DENTIST_____

MEDICAL HISTORY
CHECK ALL THAT APPLY:

DIABETES ____	ANEMIA ____	PROLONGED BLEEDING ____
PNEUMONIA ____	EPILEPSY ____	FAINTING/DIZZINESS _____
HEART TROUBLE ____	ASTHMA ____	NERVOUS DISORDER _____
RHEUMATIC FEVER ____	KIDNEY PROBLEMS ____	LIVER PROBLEMS _____
BONE DISORDERS ____	TUBERCULOSIS _____	ENDOCRINE PROBLEMS ____
HEPATITIS ____	GLAUCOMA ____	HIV/AIDS _____

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN: _____
HISTORY OF ALLERGIES OR DRUG SENSITIVITY: _____
(FEMALES) PREGNANCY YES _____ NO _____
HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? _____
ARE YOU AWARE OF HAVING A MOUTH BREATHING HABIT? _____
HAVE YOU EVER SEEN AN ORTHODONTIST OR HAD ORTHODONTIC TREATMENT? _____
DATE OF LAST DENTAL EXAMINATION? _____
WHAT ARE YOUR GOALS FOR YOUR ORTHODONTIC TREATMENT?
_____

SIGNATURE _____ DATE _____