

Dr. Brian Hurd *Orthodontist*

ADULT HEALTH HISTORY FORM

PATIENTS NAME _____

SEX _____

BIRTHDATE _____

ADDRESS _____

HOME PHONE _____

EMPLOYER _____

WORK PHONE _____

Person financially responsible: *Self* *Other: (Please specify)* _____

Have we treated any other family member? Y N If so, please list names: _____

Do you have general dental insurance ? Y N Do you have orthodontic insurance? Y N

Patient's dentist: _____ Patient's Physician _____

Whom may we thank for referring you to our practice? _____

What is your reason for arranging an orthodontic consultation? _____

Has any family member a similar bite or jaw problem? Y N

Have you previously worn any orthodontic appliance such as retainers, braces, spacers etc: Y N

Difficulty breathing through nose? Y N Unusual number of headaches? Y N

Do your jaws click, crack or lock upon opening? Y N

Do you grind or clench your teeth? Y N

Do you have any of the following? (Please circle yes or no)

Asthma	Yes	No
Hayfever	Yes	No
Bleeding Disorder	Yes	No
Hepatitis	Yes	No
Mononucleosis	Yes	No
Rheumatic Fever	Yes	No
Epilepsy	Yes	No
Diabetes	Yes	No
Kidney Disease	Yes	No
Liver Disease	Yes	No
Heart Problems	Yes	No
Latex Allergy	Yes	No
HIV	Yes	No
Joint Replacement	Yes	No

Are you under a physician's care? Y N

Are you taking any medication? Y N If so, please specify _____ -

Does the patient have any allergies or drug reactions? Y N If so, please describe:

Any additional comments?

Our privacy protocols comply with privacy legislation, standards of our regulatory body, the Royal College of Dental Surgeons of Ontario and the law. Only necessary information is collected and we only share information with your consent.

I hereby consent that Dr. Hurd or his designated staff may release any information pertaining to orthodontic treatment to my dentist or related health professional:

Date _____

Signature: _____