Thomas J. Eigo, DDS. PC 516 Glen Street ♦ Glens Falls NY 12801 ♦ (518) 793-5138
Specializing in Orthodontics

WELCOME!

Thank you for selecting our orthodontic healthcare team! We will strive to provide you with the best possible orthodontic care. Please complete both sides of this health history form in ink prior to coming to our office. All information will be kept confidential. If you have any questions or need assistance, please ask—we'll be happy to help.

MEDICAL-DENTAL HISTORY FORM FOR ADULT PATIENTS

CONTACT INFORMATION:			
Patient's name: (Last)	(First)	(Middle)	
Birthdate: / / Age:	Sex: Male ( ) Female ( )	Home Phone:	
Mailing address:			
City/Town:	State:	Zip	
Work Phone #	Cell Phone #		
Marital status: Single ( ) Married ( ) Widowed ( ) Separated ( ) Divorced ( )			
In case we can not reach you: Person to contact:		Phone:	
Relationship to patient:			
MEDICAL INFORMATION: (*Please also complete questions on back of this form*)			
Name of your dentist:	Phone # ( )		
Address:	City/Town:	State:	Zip:
Date of most recent dental examination: / /			
How often do you brush your teeth?	Floss?		
Name of your primary care physician:		Phone:	
Address:	City/Town	State:	Zip:
Date of most recent physical exam: / /			
PERSONAL INFORMATION:			
Any other family members treated in our office?			
Your present weight:	Present height:		
Your Interests, hobbies or avocations:			
INSURANCE INFORMATION:			
Orthodontic Insurance Coverage: Yes ( ) No ( )			
Primary (Dental) Insurance Company:	Policy #:		
Secondary (Dental) Insurance Company:	Policy #:		
Name of Insured:	Phone #:		
Social Security Number:	Date of Birth:		
Mailing address of insured: (*if different than patient information above*)			
City/Town:	State:	Zip:	
Employer of Insured:	Phone #:		

Our office maintains strict confidentiality of all patient records. It is for that reason that we ask you to sign below as permission to release diagnostic findings to the patient's dentist.

______________________________ ____________________
Signature Date

For the following questions please circle YES/NO or DON'T KNOW (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. Thank you.

Yes No DK/U -Does the patient follow directions?
Yes No DK/U- Does the patient brush his/her teeth conscientiously?
Yes No DK/U- Does patient have learning disabilities or need extra help with instructions?
Yes No DK/U- Is the patient sensitive, self/conscious?

Medical History

Yes no dk/u Mental health/behavioral problems?
Yes no dk/u Vision, hearing, tasting or speech difficulties?
Yes no dk/u Loss of weight recently, poor appetite?
Yes no dk/u Do you have a normal diet?
Yes no dk/u Excessive bleeding, black and blue tendency, Anemia or bleeding disorder?
Yes no dk/u High or low blood pressure?
Yes no dk/u Tires easily?
Yes no dk/u Cardiovascular problem (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 Frequent headaches, colds, sore throats?
Yes no dk/u 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 or drug reactions?
Yes no dk//u Are you taking medication, nutrient supplements or Non-prescription medicine? ___________________
Yes no dk/u Operations (surgical procedures)?
Yes no dk/u Hospitalized for ______________________________
Yes no dk/u Other physical problems or symptoms?

Date of most recent physical exam? _________________

Realizing that successful treatment greatly depends on 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 TO THIS HISTORY RECORD OR MEDICAL/DENTAL STATUS I WILL SO INFORM THIS PRACTICE.

_________________________________ ____________________
Signature Date

Dental History

Yes no dk/u Started teething early or late?
Yes no dk/u Primary (baby) teeth removed that were not loose?
Yes no dk/u Permanent or extra(supernumery teeth removed)?
Yes no dk/u Supernumery(extra) or congenitally missing teeth?
Yes no dk/u Chipped or otherwise injured primary (baby) or permanent teeth?
Yes no dk/u Teeth sensitive to hot or cold?
Yes no dk/u Jaw fractures, cysts, infections?
Yes no dk/u "Dead teeth" / root canals?
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/cold sores?
yes no dk/u Is child taking any form of fluoride?
Yes no dk/u Thumb, finger sucking habit? Until_________
Yes no dk/u Abnormal swallowing (tongue thrust) problem?
Yes no dk/u History of speech problems?
Yes no dk/u Any pain in jaw or ringing in ears?
Yes no dk/u Does patient experience pain or soreness in muscles of the face or around ears?
Yes no dk/u Other physical problems or symptoms?
Yes no dk/u Being treated by another health professional?
Yes no dk/u Difficulty encountered in chewing or jaw opening?
Yes no dk/u Aware of loose, broken or missing restorations(fillings)?
Yes no dk/u Any teeth irritating cheek, lip, tongue or palate?
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 relationship?