**CONFIDENTIAL**

**Medical Dental History Form for Adult Patients**


## PATIENT

Dr. Mariana Orthodontics - 770 W Main St. Monroe, WA 98272 - (360) 805-0900

Date _____

Patient's Last name _____ First name _____ Middle initial _____

Title ☐ Mr.☐ Mrs.☐ Miss ☐ Dr.☐ Other I prefer to be called_____

Birth date _____ Social Security # _____

What sex were you assigned on your birth certificate?☐Male☐Female

What is your current gender identification? ☐Male ☐Female ☐Other

What are your preferred pronouns? _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home address _____ City, State, Zip code_____

Cell phone _____ Home phone _____

Work phone _____

E-mail address(es) _____

Occupation _____Employer_____

## CLOSEST RELATIVE

Spouse or closest relative's name(s) _____ Relationship to patient _____

Title ☐ Mr. ☐ Mrs. ☐ Miss ☐ Dr. ☐ Other Prefers to be called _____

Address *(if different than patient address)* _____

Cell phone _____ Home phone _____ Work phone _____

## DENTIST

Patient's Dentist _____ Address, City, State _____

Last seen _____ Reason_____ Next appointment _____

Other dentists/dental specialists now being seen: Name _____ City, State _____

Reason _____

## PHYSICIAN

Patient's Physician _____ City, State _____

Last seen _____ Reason _____ Next appointment _____

Most recent physical exam _____

Other physicians/health care providers being seen now:

Name _____ City, State _____ Reason _____

Name _____ City, State _____ Reason _____

## GENERAL INFORMATION

What concerns you about your teeth? _____

Who suggested that you might need orthodontic treatment?_____

Why did you select our office?_____

Have you had any previous orthodontic treatment? Please describe_____

Have any other family members been treated in this office? Please name them. _____

Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain. _____

## FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____

Address (*if different from page 1*)_____ City, State, Zip _____

Cell phone _____ Home phone _____

E-mail address(es) _____

Social Security #_____ Employer _____

## DENTAL INSURANCE

Primary policy holder's full name _____ Birthdate _____

Social Security # _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID # _____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't know

Secondary policy holder's full name _____ Birthdate _____

Social Security #_____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID # _____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't know

## MEDICAL INSURANCE

Policy holder's full name _____

Insurance company _____

*Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation. For the following questions mark yes, no, or don't know/understand (dk/u).*

## MEDICAL HISTORY

### Now or in the past, have you had:

☐ yes ☐ no ☐ dk/u Have you ever taken intravenous medication for bone disorders or cancer such as bisphosphonates as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate)?

☐ yes ☐ no ☐ dk/u Have you ever taken oral medication for bone disorders such as bisphosphonates Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate)?

☐ yes ☐ no ☐ dk/u Hereditary or developmental conditions?
☐ yes ☐ no ☐ dk/u Bone fractures, or major injuries?
☐ yes ☐ no ☐ dk/u Any injuries to face, head, neck?
☐ yes ☐ no ☐ dk/u Arthritis or joint problems?
☐ yes ☐ no ☐ dk/u Endocrine or thyroid problems?
☐ yes ☐ no ☐ dk/u Diabetes or low sugar?
☐ yes ☐ no ☐ dk/u Kidney problems?
☐ yes ☐ no ☐ dk/u Cancer, tumor, radiation treatment or chemotherapy?
☐ yes ☐ no ☐ dk/u Stomach ulcer, hyperacidity, acid reflux?
☐ yes ☐ no ☐ dk/u Immune system problems?
☐ yes ☐ no ☐ dk/u History of osteoporosis?
☐ yes ☐ no ☐ dk/u Gonorrhea, syphilis, herpes, sexually transmitted diseases?
☐ yes ☐ no ☐ dk/u AIDS or HIV positive?
☐ yes ☐ no ☐ dk/u Hepatitis, jaundice or other liver problem?
☐ yes ☐ no ☐ dk/u Polio, mononucleosis, tuberculosis, pneumonia?
☐ yes ☐ no ☐ dk/u Seizures, fainting spells, neurologic problem?
☐ yes ☐ no ☐ dk/u Mental health disturbance or depression?
☐ yes ☐ no ☐ dk/u Vision, hearing, or speech problems?
☐ yes ☐ no ☐ dk/u History of eating disorder (anorexia, bulimia)?
☐ yes ☐ no ☐ dk/u High or low blood pressure?
☐ yes ☐ no ☐ dk/u Excessive bleeding or bruising, anemia?
☐ yes ☐ no ☐ dk/u Chest pain, shortness of breath, tire easily, swollen ankles?
☐ yes ☐ no ☐ dk/u Heart defects, heart murmur, rheumatic heart disease?
☐ yes ☐ no ☐ dk/u Angina, arteriosclerosis, stroke or heart attack?
☐ yes ☐ no ☐ dk/u Skin disorder (other than common acne)?
☐ yes ☐ no ☐ dk/u Do you eat a well-balanced diet?
☐ yes ☐ no ☐ dk/u Frequent headaches or migraines?
☐ yes ☐ no ☐ dk/u Frequent ear infections, colds, throat infections?
☐ yes ☐ no ☐ dk/u Asthma, sinus problems, hayfever?
☐ yes ☐ no ☐ dk/u Tonsil or adenoid condition?
dk/u Do you frequently breathe through your mouth?

### Have you had allergies or reactions to any of the following:

☐ yes ☐ no ☐ dk/u Latex (gloves, balloons)
☐ yes ☐ no ☐ dk/u Metals (jewelry, clothing snaps)
☐ yes ☐ no ☐ dk/u Acrylics
☐ yes ☐ no ☐ dk/u Local anesthetics (novocaine, lidocaine, xylocaine)
☐ yes ☐ no ☐ dk/u Aspirin
☐ yes ☐ no ☐ dk/u Ibuprofen (Motrin, Advil)
☐ yes ☐ no ☐ dk/u Penicillin
☐ yes ☐ no ☐ dk/u Other antibiotics
☐ yes ☐ no ☐ dk/u Plant pollens
☐ yes ☐ no ☐ dk/u Animals
☐ yes ☐ no ☐ dk/u Foods
☐ yes ☐ no ☐ dk/u Other substances _____

## DENTAL HISTORY

### Now or in the past, have you had:

☐ yes ☐ no ☐ dk/u Permanent or extra (supernumerary) teeth removed?
☐ yes ☐ no ☐ dk/u Supernumerary (extra) or congenitally missing teeth?
☐ yes ☐ no ☐ dk/u Chipped or injured primary or permanent teeth?
☐ yes ☐ no ☐ dk/u Any sensitive or sore teeth?
☐ yes ☐ no ☐ dk/u Bleeding gums, bad taste or mouth odor?
☐ yes ☐ no ☐ dk/u Jaw fractures, cysts, infections?
☐ yes ☐ no ☐ dk/u Any teeth treated with root canals or pulpotomies?
☐ yes ☐ no ☐ dk/u "Gum boils," frequent canker sores or cold sores?
☐ yes ☐ no ☐ dk/u History of speech problems or speech therapy?
☐ yes ☐ no ☐ dk/u Difficulty breathing through nose?
☐ yes ☐ no ☐ dk/u Food impaction between the teeth?
☐ yes ☐ no ☐ dk/u Mouth breathing habit or snoring at night?
☐ yes ☐ no ☐ dk/u History of speech problems?
☐ yes ☐ no ☐ dk/u Frequent oral habits (sucking finger, chewing pen, etc.)?
☐ yes ☐ no ☐ dk/u Teeth causing irritation to lip, cheek or gums?
☐ yes ☐ no ☐ dk/u Abnormal swallowing (tongue thrust)?
☐ yes ☐ no ☐ dk/u Tooth grinding or clenching?
☐ yes ☐ no ☐ dk/u Clicking, locking in jaw joints?
☐ yes ☐ no ☐ dk/u Soreness in jaw muscles or face muscles?
☐ yes ☐ no ☐ dk/u Ringing in ears, difficulty in chewing or opening jaw?
☐ yes ☐ no ☐ dk/u Have you ever been treated for "TMJ" or "TMD" problems?
☐ yes ☐ no ☐ dk/u Any broken or missing fillings?
☐ yes ☐ no ☐ dk/u Any serious trouble associated with previous dental treatment?
☐ yes ☐ no ☐ dk/u Have you ever been diagnosed with gum disease or pyorrhea?
☐ yes ☐ no ☐ dk/u Have you ever had an orthodontic consultation ortreatment before now?

## PATIENT HEALTH INFORMATION

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you take.

Do you take antibiotic pre-medication before any dental procedures? ☐ Yes ☐ No

Medication _____ Taken for _____ Medication _____ Taken for_____

Medication _____ Taken for _____ Medication _____ Taken for _____

Have you ever taken any medications to strengthen your bones? Please describe. _____

Do you or have you ever had a substance abuse problem? _____

Have you chewed tobacco ☐ Yes ☐ No or smoked any substance or vaped? ☐ Yes ☐ No

If yes, what is the frequency? _____

Have you noticed any changes in your face or jaws? _____

Any other physical problems? _____

How often do you brush? _____ How often do you floss? _____

Are you pregnant? ☐ Yes ☐ No Are you trying to become pregnant? ☐ Yes ☐ No

## FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders _____

Diabetes _____

Arthritis _____

Severe allergies _____

Unusual dental problems _____

Jaw size imbalance _____

Other family medical conditions? _____

## RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature _____ Date_____

I have read the above questions and understand them. 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. I will notify my orthodontist of any changes in my medical or dental health.

Signature _____ Date_____

## MEDICAL HISTORY UPDATES OR CHANGES

Changes _____
Patient Signature _____ Date_____
Dental Staff Signature _____ Date_____

Changes _____
Patient Signature _____ Date_____
Dental Staff Signature _____ Date_____

Changes _____
Patient Signature _____ Date_____
Dental Staff Signature _____ Date_____

# Privacy Practices

**Mariana Muguerza, DDS, MSD Acknowledgement of Receipt of Statement of Privacy Practices**
**ACKNOWLEGMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES**

**I acknowledge that I have received a copy of the Statement of Privacy Practices of the office of Mariana Muguerza, DDS. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that night occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.**

**Mariana Muguerza, DDS reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.**

**ADDITIONAL DISCLOSURE AUTHORIZATION In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO" Without indicating "YES" in answer to each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPPA rules.)**

**Please click on the link to view our Privacy Policy before submitting your forms**

marianaorthodontics.com/wp-content/uploads/2022/09/HIPAA-Notice-Privacy-Practices.pdf

**Spouse only** Yes ◉ No ○

**Any Member of my immediate family: (Spouse, Children, Children's Spouses)** Yes ○ No ○

**Any Member of extended family: (Parents, Grandchildren)**

**Other:**

**Signature** _____

Date_____

# Release and Waiver

**I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company**

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**I have read the above questions and understand them. 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. I will notify my orthodontist of any changes in my medical or dental health.**

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