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# Health History

## About the Patient

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First MI Mr Mrs Ms Dr

E-mail Address: \_\_\_\_\_

I prefer to be called: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ SS#: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Ap/ Condo #

Single  Married  Divorced/Separated  Minor

Hm #: (\_\_\_\_) \_\_\_\_\_ Cell/Other# \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ DL#: \_\_\_\_\_

Employer or School & Grade: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City State Zip

How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_

Where & when are best times to reach you? \_\_\_\_\_

Whom may we Thank for referring you? \_\_\_\_\_

Names & ages of children or siblings: \_\_\_\_\_

Previous / Present Dentist: \_\_\_\_\_  
(Please Circle)

## Orthodontic Insurance

### Primary

Orthodontic Coverage?  Yes  No Dental Coverage?  Yes  No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

City State Zip  
 Insurance Phone: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

Insured's Birthdate: \_\_\_/\_\_\_/\_\_\_ Insured's SS#: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City State Zip

### Secondary

Orthodontic Coverage?  Yes  No Dental Coverage?  Yes  No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

City State Zip  
 Insurance Phone: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

Insured's Birthdate: \_\_\_/\_\_\_/\_\_\_ Insured's SS#: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City State Zip

## Person Responsible for Account

*Responsible party is patient or parent/guardian bringing child to appointment*

Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ DL#: \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_ SSN # \_\_\_\_\_

### Person to contact in case of an emergency

Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Hm #: (\_\_\_\_) \_\_\_\_\_ Wk #: (\_\_\_\_) \_\_\_\_\_

### Release

I authorize the doctor to perform diagnostic procedures and treatment as may be necessary for proper dentofacial care.

I authorize release of any information concerning my (or my child's) health care for the purpose of evaluation and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care for advice and treatment to interdisciplinary team members.

I consent to release of credit reports and information regarding my credit history to the doctor(s).

I authorize the taking of photographs, radiographs and other diagnostic records before, during and after treatment, and to the use of the same by the doctor or interdisciplinary team members in scientific presentations or scientific literature.

Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Guardian: \_\_\_\_\_ Updated: \_\_\_\_\_

# Medical History

Do you have a personal physician?  Yes  No

Physician's Name: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Your current physical health is:  Good  Fair  Poor

For Females: Are you Pregnant?  Yes  No Week #: \_\_\_\_\_

Are you currently under the care of a physician for any medical condition?

Please explain: \_\_\_\_\_

Do you smoke or use tobacco in any other form?  Yes  No

Are you taking any prescription / over-the-counter drugs?  Yes  No

Please list each one: \_\_\_\_\_

Have you ever had any of the following diseases or medical problems?  
Please circle Y-Yes or N-No

- |  |                                     |
|--|-------------------------------------|
| Y N Abnormal Bleeding / Hemophilia     | Y N Herpes/Fever Blisters           |
| Y N AIDS                               | Y N High Blood Pressure             |
| Y N Alcohol / Drug Abuse               | Y N HIV-Positive test or exposure   |
| Y N Anemia                             | Y N Hospitalized for any reason     |
| Y N Arthritis                          | Y N Kidney Problems                 |
| Y N Artificial Bones / Joints / Valves | Y N Liver Disease                   |
| Y N Asthma                             | Y N Low Blood Pressure              |
| Y N Blood Transfusion                  | Y N Lupus                           |
| Y N Cancer / Chemotherapy              | Y N Mitral Valve Prolapse           |
| Y N Colitis                            | Y N Pacemaker                       |
| Y N Congenital Heart Defect            | Y N Psychiatric / Nervous Disorders |
| Y N Diabetes                           | Y N Radiation Treatment             |
| Y N Difficulty Breathing               | Y N Rheumatic / Scarlet Fever       |
| Y N Emphysema                          | Y N Seizures                        |
| Y N Epilepsy                           | Y N Shingles                        |
| Y N Fainting Spells                    | Y N Sickle Cell Disease / Traits    |
| Y N Frequent Headaches                 | Y N Sinus Problems                  |
| Y N Glaucoma                           | Y N Stroke                          |
| Y N Hay Fever                          | Y N Thyroid Problems                |
| Y N Heart Attack and or Surgery        | Y N Tuberculosis (TB)               |
| Y N Heart Murmur                       | Y N Ulcers                          |
| Y N Hepatitis                          | Y N Sexually Transmitted Disease    |

Please list any serious medical condition(s) that you have ever had, or elaborate on any of the above. \_\_\_\_\_

Have you ever been told that you need antibiotics prior to dental treatment?  Yes  No

Please list any drugs/materials that you are allergic to: (ex. latex, penicillin) \_\_\_\_\_

# Dental History

What are your main concerns that you would like orthodontics to accomplish? \_\_\_\_\_

Have you ever had or been evaluated for orthodontic treatment?  Yes  No

Have you ever been treated for or told you have gum disease?  Yes  No

Have you ever had a serious / difficult problem associated with any previous dental work?  Yes  No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)?  Yes  No

Your current dental health is:  Good  Fair  Poor

When was your last dental cleaning? \_\_\_\_\_

Have you ever had an injury to your: **Mouth Teeth Chin** (Please Circle)

Do you have any speech problems? \_\_\_\_\_

Do you generally breathe through your mouth?  Yes  No  
If yes, please circle: **While Awake While Asleep**

Are you happy with the way your smile looks?  Yes  No

If no, what would you change? \_\_\_\_\_

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**OFFICE USE ONLY**

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I verbally reviewed the medical / dental information with the patient named herein.

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Comments: \_\_\_\_\_

**Our office is HIPAA compliant & is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC & the ACA.**

## MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit?

Y N \_\_\_\_\_ Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_

If Yes, please explain: \_\_\_\_\_

\_\_\_\_\_ Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_

Has there been any change in your health status since your last visit?

Y N \_\_\_\_\_ Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_

If Yes, please explain: \_\_\_\_\_

\_\_\_\_\_ Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_