Clover's

PATIENT HISTORY FORM

PATIENT INFORMATION

DATE ____________ PATIENT'S NAME ______________________________________
LAST FIRST MI

ADDRESS ______________________________________
STREET CITY ZIP

BIRTHDATE ____________ SOCIAL SECURITY # ____________ BEST PHONE ____________

IF A PATIENT IS A MINOR, GIVE PARENT'S OR GUARDIAN'S NAME ______________________________________

SCHOOL ____________ WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ____________

RESPONSIBLE PARTY INFORMATION

PATIENT'S NAME ______________________________________ RELATIONSHIP TO PATIENT ____________
LAST FIRST MI

ADDRESS ______________________________________
STREET CITY ZIP

CELL/OTHER PHONE ____________ TEXT Y N HOME PHONE # ____________ WORK PHONE # ____________

EMAIL ADDRESS ____________ SOCIAL SECURITY # ____________ BIRTHDATE ____________

EMPLOYER ____________ OCCUPATION ____________ YEARS EMPLOYED ____________

SPOUSE OR OTHER BILLING PARTY ______________________________________ RELATIONSHIP TO PATIENT ____________
LAST FIRST MI

ADDRESS ______________________________________
STREET CITY ZIP

CELL/OTHER PHONE ____________ TEXT Y N HOME PHONE # ____________ WORK PHONE # ____________

EMAIL ADDRESS ____________ SOCIAL SECURITY # ____________ BIRTHDATE ____________

EMPLOYER ____________ OCCUPATION ____________ YEARS EMPLOYED ____________

DENTAL INSURANCE INFORMATION

INSURED'S NAME ______________________________________ INSURED SOCIAL SECURITY # ____________

INSURANCE COMPANY ____________ GROUP# ____________ LOCAL# ____________

INSURANCE COMPANY ADDRESS ______________________________________ PHONE # ____________

DO YOU HAVE DUAL COVERAGE? YES ________ NO ________

INSURED'S NAME ______________________________________ INSURED SOCIAL SECURITY # ____________

INSURANCE COMPANY ____________ GROUP# ____________ LOCAL# ____________

INSURANCE COMPANY ADDRESS ______________________________________ PHONE # ____________

EMERGENCY CONTACT INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU ______________________________________ PHONE # ____________

COMPLETE ADDRESS ______________________________________
STREET CITY ZIP

I UNDERSTAND THAT, WHERE APPROPIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED.

SIGNATURE (PATIENT OR PARENT/GUARDIAN'S SIGNATURE IF MINOR) ______________________________________

UPDATES)DATE & INITIAL) ____________

Clover's
PATIENT HISTORY FORM

MEDICAL HISTORY

PATIENT'S NAME ______________________ TODAY'S DATE ____________

PHYSICIAN NAME ______________________ DATE OF LAST VISIT ____________

ADDRESS ______________________ PHONE # ____________

PLEASE CIRCLE **YES** OR **NO** (IF YES, PLEASE FILL IN DETAILS)

YES NO ARE YOU TAKING ANY MEDICATION? ____________

YES NO ARE YOU ALLERGIC TO ANY MEDICATIONS? ____________

YES NO DO YOU HAVE ANY HISTORY OF MAJOR ILLNESS? ____________

YES NO HAVE YOU HAD ANY OPERATIONS? ____________

YES NO HAVE YOU EVER BEEN INVOLVED IN A SERIOUS ACCIDENT? ____________

YES NO HAVE YOU EVER SEEN A PHYSICIAN IN THE LST 12 MONTHS? WHY? ____________

CIRCLE ANY OF THE MEDICAL CONDITIONS BELOW THAT YOU HAVE HAD OR CURRENTLY HAVE:

ABNORMAL BLEEDING/HEMOPHILIA	DIABETES	HEPATITUS/LIVER PROBLEMS	PNEUMONIA
ANEMIA	DIZZINESS	HERPES	PROLONGED BLEEDING
ARTHRITIS	EPILEPSY	HIGH BLOOD PRESSURE	RADIATION/CHEMOTHERAPY
ASTHMA OR HAY FEVER	HIV/AIDS	GASTROINTESTINAL DISORDERS	RHEUMATIC FEVER
BONE DISORDERS	HEART PROBLEMS	KIDNEY PROBLEMS	TUBERCULOSIS
CONGENITAL HEART DEFECT	HEART MURMUR	NERVOUS DISORDERS	TUMOR OR CANCER

ARE THERE ANY MEDICAL CONDITIONS WE HAVE NOT DISCUSSED THAT YOU FEEL WE SHOULD BE AWARE OF? ____________

DENTAL HISTORY

GENERAL DENTIST ______________________ DATE OF LAST VISIT ____________

WHAT CONCERNS YOU MOST ABOUT YOUR TEETH? ____________

YES NO ARE YOU PRESENTLY IN ANY DENTAL PLAN? ____________

YES NO HAVE YOU EVER EXPRIENCED ANY UNFAVORABLE REACTION TO DENTISTRY? ____________

YES NO HAVE YOU EVER LOST OR CHIPPED ANY TEETH? ____________

YES NO HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? ____________

YES NO IS THERE ANY PART OF YOUR MOUTH SENSITIVE TO TEMPERATURE? WHERE? ____________

YES NO IS THERE ANY PART OF YOUR MOUTH SENSITIVE TO PRESSURE? WHERE? ____________

YES NO DO YOUR GUMS BLEED WHEN YOU BRUSH? ____________

YES NO DO YOU HAVE ANY TYPE OF THUMB OR TONGUE HABIT? ____________

YES NO ARE YOU A MOUTH BREATHER? ____________

YES NO HAVE YOU EVER SEEN AN ORTHODONTIST? IF YES, WHO AND WHEN? ____________

YES NO WHAT IS YOUR ATTITUDE TOWARD RECEIVING ORTHODONTIC TREATMENT? ____________

YES NO HAS ANYONE IN YOUR FAMILY RECEIVED ORTHODONTIC TREATMENT? ____________

HOW DID THEY FEEL ABOUT THE RESULTS? ____________

YES NO DO YOUR TEETH OR JAWS EVER FEEL UNCOMFORTABLE WHEN YOU WAKE IN THE MORNING? ____________

YES NO ARE YOU AWARE OF YOUR JAW CLICKING OR POPPING? ____________

YES NO ARE YOU AWARE OF CLENCHING YOUR TEETH DURING THE DAY? ____________

YES NO DO YOU HAVE “TENSION” HEADACHES? ____________

www.cloverortho.com | 803.653.6979
1474 Hwy 55 E, Suite 100 • Clover, SC 29710

Clover's

PATIENT HISTORY FORM

YES NO DO YOU HAVE "TENSION" HEADACHES? ______

YES NO HAVE YOU EVER EXPERIENCED CHRONIC RINGING IN YOUR EARS? ______

YES NO IF THE PATIENT IS UNDER 16, HEIGHT OF PARENTS? MOM ______ DAD ______

YES NO ARE YOU AWARE THAT SOME APPOINTMENTS WILL BE DURING SCHOOL/WORK HOURS? ______

FEMALE PATIENTS ONLY

YES NO ARE YOU PREGNANT? ______

YES NO HAS MENSTRUATION STARTED? ______

BENEFITS

BENEFITS OF ORTHODONTICS: AESTHETICS, HEALTH AND FUNCTION. ORTHODONTICS IS A SERVICE THAT PROVIDES AN IMPROVEMENT IN THE APPEARANCE OF TEETH, IN THE GENERAL FUNCTION OF TEETH, AND IN GENERAL DENTAL HEALTH. TEETH, GUMS, AND JAWS ARE AN INTRICATE BODY PART AND CAN FAIL TO RESPOND TO TREATMENT. IF GOOD ORAL HYGIENE IS NOT PRACTICED, TOOTH DECAY AND ENLARGED GUMS CAN RESULT. JOINT DISCOMFORT AND ROOT SHORTENING ARE OBSERVED IN A SMALL PERCENTAGE OF CASES. TEETH CHANGE THROUGHOUT OUR LIFETIME AND THERE CAN BE SOME MOVEMENT OF THE TEETH AND SOME CHANGE AFTER TREATMENT. I HAVE READ AND UNDERSTAND THIS PARAGRAPH. I ALSO UNDERSTAND THAT MY DIAGNOSTIC RECORDS AND MY NAME MAY BE USED FOR EDUCATIONAL AND PROMOTIONAL PURPOSES. I HAVE TRUTHFULLY ANSWERED ALL OF THE ABOVE QUESTIONS AND AGREE TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL OR DENTAL HISTORY. IN ADDITION, I AUTHORIZE DR. GOODY THOMAS TO PERFORM A COMPLETE ORTHODONTIC EVALUATION.

SIGNATURE ______ DATE ______