MORRONE KAYE MEDICAL/DENTAL HISTORY - ADULT

Patient Name: ___________________________ Date of Birth: ________________ Age: _____________

Please check if you have had any of the following:

( ) Allergy to Medications
( ) Digestion Problems - GERD
( ) Heart Murmur Pre-Med/No Pre-Med
( ) Blood Disorder
( ) Fainting/Dizziness
( ) Kidney/Liver Disorders
( ) Orthopedic Implant
( ) Bronchitis
( ) Tonsils/Adenoids Removed
( ) Allergy to Plastic/Latex
( ) Emotional Problems
( ) Convulsions/Epilepsy
( ) Disabilities
( ) Rheumatic Fever
( ) High/Low Blood Pressure
( ) Frequent Headaches
( ) Facial Injuries - Mouth,Chin
( ) Frequent Colds
( ) Strep Infections
( ) Cancer
( ) Diabetes
( ) Asthma
( ) ADD/ADHD
( ) HIV

Please explain any checked answers: ____
____
____

Is there any other significant medical history you feel we should know? ____________________________________
____
____

Please list any medications currently taken: ____
____

Is antibiotic premedication needed for dental visits? (Please circle one) YES NO

Physician's Name ____
Dentist's Name ____ **Last Dental Visit** ____________________________

Please check if you currently have any of the following oral habits:

( ) Nail Biting
( ) Clenching/Grinding Teeth
( ) Speech Problems
( ) Gum Chewing
( ) Thumb/Finger Sucking
( ) Tongue Thrusting
( ) Mouth Breathing
( ) Lip/Cheek Biting
( ) Other - Please List
____
____
____

Please list any significant dental or medical history that may affect your treatment (ie missing teeth, jaw alignment problems, growth disturbances, etc.) : ____
____
____

Please list all children's legal names and birthdates: ____
____

Whom may we thank for referring you to our office? ____
Please state your reason for this consultation: ____
Have you previously seen an orthodontist? YES NO If so, who? ________________________________
Was any treatment performed? YES NO If yes, please explain ___________________________________
Have any oral x-rays recently been taken by your dentist or a specialist? YES NO
Are you or a family member currently connected to Facebook? YES NO

The above information is true to my knowledge. I give my consent for examination by the doctors and staff of Morrone & Kaye Orthodontics, P.A.

____
Signature Print Name Date

7/09

MORRONE KAYE MEDICAL/DENTAL HISTORY - ADULT

FAMILY INFORMATION

Your Name : ________________________________ **E-mail Address :** _________________________________
Current Address : ____
Length at Address : _________ **Phone : (W)**_______________ **(H)**_______________ **(C)**________________
SS# _______________________ **Marital Status : ( ) Single ( ) Married ( ) Divorced ( ) Widowed**
Occupation : ____________________________________ **Employer :** _________________________________
Employer's Address : _______________________________________ **Years with this Employer** _________

Spouse Name : ________________________________ **E-mail Address :** ______________________________
Current Address : ____
Length at Address : _________ **Phone : (W)**_______________ **(H)**_______________ **(C)**_______________
SS# _______________________ **Marital Status : ( ) Single ( ) Married ( ) Divorced ( ) Widowed**
Occupation : ____________________________________ **Employer :** _________________________________
Employer's Address : _______________________________________ **Years with this Employer** _________

DENTAL INSURANCE INFORMATION

Primary Dental Insurance :

Subscriber's Name : ____
Date of Birth : _____________________________ **SS#** ____
Insurance Company : ____
Insurance Company Address : ____
Insurance Company Phone # _____________________________**Insurance ID #** ________________________
Group # _____________________________ **Local #** ____________________________
Do you have orthodontic coverage under this plan ? YES NO
Do you have dual coverage ? YES NO If yes, please complete secondary information below.

Secondary Dental Insurance :

Subscriber's Name : ____
Date of Birth : _____________________________ **SS#** ____
Insurance Company : ____
Insurance Company Address : ____
Insurance Company Phone # _____________________________**Insurance ID #** ________________________
Group # _____________________________ **Local #** ____________________________
Do you have orthodontic coverage under this plan ? YES NO