HOSKINSON ORTHODONTICS
FOR CHILDREN & ADULTS

Adult Medical History

Today's date:_____

First Name:_____ Last Name:_____

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

Primary Care Physician:_____ Month/Year Physical Exam:_____
Are you currently being treated by a physician? ○ Yes ○ No
Are you currently taking any prescription or over-the-counter medications? ○Yes ○ NO
List:_____

_____

Have you had any serious illnesses or operations? If yes, describe:_____

Check if you have/had history of the following:

☐Anemia
☐Diabetes/low blood sugar
☐Kidney Disease
☐Thyroid Problem
☐Diabetes/low blood sugar
☐Cancer
☐Radiation/Chemotherapy
☐Hepatitis
☐Heart Defect, murmur,
Rheumatic heart disease
infections
☐Pacemaker
☐Vision,Hearing,Speech Problem
☐Female-concern w/ pregnancy and X-Rays

☐ Endocrine/Thyroid Disorder
☐ Asthma,Sinus problem,hayfever
☐ Birth defects,hereditary problem
☐ Skin Rash
☐ Lyme Disease
☐High or low blood pressure
☐Liver Disease
☐Tobacco/Chemical use
☐Tuberculosis/Mononucleosis
☐Frequent ear infections,colds,throat

☐Osteoporosis/Osteopenia
☐Taken bisphosphonates ie. Foxamax,
☐ Birth Control Pill_____

Allergies: *Check if allergy or reaction to the following*

☐Latex
☐Aspirin,Ibuprofen
☐Acrylics
☐Animals
☐Plant pollens

☐Local anesthetics(novacaine,lidocaine,xylocaine)
☐Metals (jewelry,clothing,snaps)
☐Antibiotics-Penicillin or other
☐Foods_____
☐Other_____

207 Mohawk Ave. Suite 1A Scotia NY 12302
518.372.3424
info@hoskinsonortho.com

HOSKINSON ORTHODONTICS
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Dental History:

General Dentist:_____ Last Visit:_____

What are the main concerns you would like orthodontics to accomplish?
Concerns: _____
_____

Have you had previous orthodontic treatment ?○Yes ○No

When:_____ Reason:_____

Check if have history:

☐Problems associated w/ previous dental treatment _____
☐Erupting teeth very early or late
☐ Primary(baby) teeth removed because
○ loose or ○ decayed
☐Sensitive or sore teeth
☐Jaw fracture,cysts, or infection
☐Teeth causing irritation to lip,cheek,gum
☐Jaw joint clicking, popping
☐Treatment for TMJ or TMD
☐Mouth breathing, Snoring
☐Nail biting
☐Injury to head/neck
☐Permanent or extra teeth removed
☐Tonsil or adenoid condition
☐Chipped or injured primary or permanent teeth
☐Lost or broken fillings
☐Teeth treated w/ root canal or pulpotomy
☐Teeth grinding or clenching
☐Soreness in jaw or face muscles
☐Diseased gums
☐Broken or missing fillings
☐Chewing/eating problem
☐removable partial denture,bridge,implants

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Patient Information-*Adult*

Patient Name: first_____ **last**_____

Date of Birth:_____

Address:_____

_____

Phone: Home_____ **Mobile**_____

Email:_____

Chief Complaint_____
_____

Prior Orthodontics_____

How Did You Find Us? *Check all that apply:*

☐ Dentist Referral _____

☐ Friend/Family Referral_____

☐ Facebook ☐ Internet Search ☐ Other_____

Phone H_____ W_____ C_____

Social Security # _____ _____ _____

Email:_____

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Person responsible for account: ☐ self ☐spouse ☐other; *if other than self*:

Name_____

Address_____

Telephone H_____ W _____C_____

*Please complete if patient has **Orthodontic Insurance** coverage.*

Primary Insurance

Insured's Name_____

Date of Birth_____ Social Security #_____

Employer_____

Workplace Address_____

Phone Number_____

Insurance Company_____

Address_____

Group # _____ ID #_____

Phone #_____

Insured's Signature (to be kept on file)_____

Secondary Insurance

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HOSKINSON ORTHODONTICS
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Insured's Name_____

Date of Birth_____ Social Security #_____

Employer_____

Workplace Address_____

Phone Number_____

Insurance Company_____
Address_____
Group#_____ ID #_____
Phone #_____

Insured's Signature (to be kept on file)_____

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