BauerHite
ORTHODONTIC SPECIALISTS
The Difference is in the Details

CONFIDENTIAL MEDICAL DENTAL HISTORY FORM FOR ADULT PATIENTS

DATE _____

PATIENT

Name _____ ☐ M ☐ F
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP

Home Phone _____ Birthdate _____ Social Security # _____

Whom may we thank for referring you to our office? _____

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Name _____ Marital Status _____
LAST FIRST MIDDLE

Residence _____
STREET CITY STATE ZIP

Mailing Address _____

How long at this address _____ E-mail Address _____

Cell Phone _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs) _____

Social Security # _____ Birthdate _____ Relationship to patient _____

Employer _____ Occupation _____ Years Employed _____

Spouse's Name _____
LAST FIRST MIDDLE

Relationship to Patient _____ Cell Phone _____

Employer _____ Occupation: _____ Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

INSURANCE INFORMATION

Insured's Name _____ Insured's Soc Sec # _____

Insurance Company _____ Group # _____ Local # _____

Insured Company Address _____

Do you have dual coverage? ☐ Yes ☐ NO If yes: _____

Insured's Name _____ Insured Soc. Sec. # _____

Insurance Company _____

Insurance Company Address _____

Insured's Employer _____

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. _____

_____

DENTIST

Patient's Dentist _____Address, City, State_____

Last seen: _____Reason _____Next Appt. _____

Other dentists/dental specialists now being seen:

Name_____City State_____

Reason_____

EMERGENCY INFORMATION

Name of nearest relative not living with you_____

Complete Address _____

Phone _____ Cell Phone _____

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 Birth defects or hereditary problems?
☐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?
☐Yes ☐No ☐ DK/U Does your child frequently breathe through his/her mouth?
☐Yes ☐No ☐ DK/U Have you ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?
☐Yes ☐No ☐ DK/U Have you ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders?
☐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?

DENTAL HISTORY

Now or in the past, have you had:

☐Yes ☐No ☐ DK/U Erupting teeth very early or very late?
☐Yes ☐No ☐ DK/U Primary (baby) teeth removed that were not loose?
☐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 Any lost or broken fillings?
☐Yes ☐No ☐ DK/U Jaw Fractures, cysts, infections?
☐Yes ☐No ☐ DK/U Any teeth treated with root canals or pulpotomies?
☐Yes ☐No ☐ DK/U 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 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 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?

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

☐Yes ☐No ☐ DK/U Local anesthetics (novocaine, lidocaine, xylocaine)
☐Yes ☐No ☐ DK/U Latex (gloves, balloons)
☐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 Metals (jewelry, clothing snaps)
☐Yes ☐No ☐ DK/U Acrylics
☐Yes ☐No ☐ DK/U Plant pollens
☐Yes ☐No ☐ DK/U Animals
☐Yes ☐No ☐ DK/U Foods
☐Yes ☐No ☐ DK/U Other substances _____

PATIENT HEALTH INFORMATION

Do you think that any of your activities affect your face, teeth or jaws? How? _____

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

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Does the patient currently have (or ever had) a substance abuse problem? _____

Do you chew or smoke tobacco? _____

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

Any other physical problems? _____

FAMILY MEDICAL HISTORY

Have the 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? _____

How often do you brush? _____

How often do you floss? _____

RELEASE AND WAIVER

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

Patient Signature _____ Date _____

I have read the above question and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any error 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 _____

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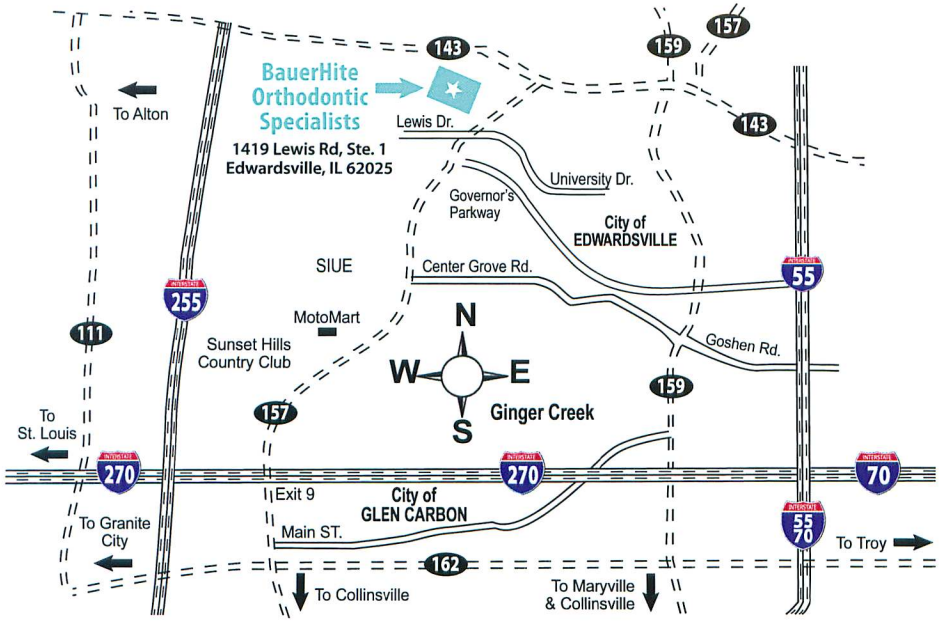
1419 Lewis Road, Suite 1
Edwardsville, IL 62025
ofc 618.692.1044
fax 844.482.3012

Dr. Elizabeth (Bauer) Hite, known as Dr. Beth, is a strong proponent of providing each patient with an individualized treatment plan to ensure the best outcomes. She truly cares for each patient, and strives to give everyone the best care while providing a fun, warm, enjoyable environment for patients and their families.

Dr. Beth has advanced specialized training in Orthodontics from the Roth Williams Center for Functional Occlusion, in addition to her traditional Orthodontic education.

She received her Dental Degree from Southern Illinois University School of Dental Medicine and her Masters Degree from St. Louis University Center for Advanced Dental Education. Her memberships include The American Association of Orthodontics, The American Dental Association, The American Dental Society, The Illinois State Society of Orthodontics, The Madison County District Dental Society, The Orthodontic Education and Research Foundation and is a certified member of The American Board of Orthodontics.

Dr. Beth lives in Glen Carbon with her husband, Dr. Ben Hite, their three children Nolan, Brynna and Braelynn. She is an active member of The Junior Service Club of Edwardsville/Glen Carbon and enjoys golfing, biking and spending time with friends and family.



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Directions to our Edwardsville office.

Take 1-270 to Edwardsville Rt. 157 (Exit 9). Follow the signs for Edwardsville and go north on Rt. 157. Turn left at the Lewis Road stop light, and right into our parking lot.

1419 Lewis Rd, Ste. 1
Edwardsville, IL 62025
(618) 692-1044