This form is fillable. Click in Patient's name to begin.

C|S|O
CRAIG & STREIGHT

(405) 321-1926

NORMAN OFFICE
706 24th Avenue NW
Norman, OK 73069

MUSTANG OFFICE
1476 N. Mustang Rd.
Mustang, OK 73064

SOUTH OKC OFFICE
10001 S Penn Ave Suite 130
Oklahoma City, OK 73159

ADULT HEALTH HISTORY FORM

DATE:

PATIENT INFORMATION

PATIENT'S NAME	PREFERRED NAME	GENDER

ADDRESS	CITY	STATE	ZIP

CELL PHONE	DAY-TIME PHONE	EMAIL

DATE OF BIRTH	AGE	EMPLOYER	SPOUSE'S NAME

HOW DID YOU HEAR ABOUT OUR OFFICE?	WHAT IS THE REASON YOU ARE SEEKING AN ORTHODONTIC EVALUATION?

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY?	PLEASE LIST OTHER FAMILY MEMBERS SEEN IN OUR OFFICE AND THEIR RELATION TO YOU
○ Yes ○ No Reason:	

MEDICAL HEALTH INFORMATION

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING HEALTH ISSUES?

	YES	NO		YES	NO		YES	NO
DIABETES	○	○	DEPRESSION / MENTAL ILLNESS	○	○	HERPES, FEVER BLISTERS	○	○
STROKE	○	○	FAINTING SPELLS, SEIZURES, EPILEPSY	○	○	JOINT REPLACEMENT OR IMPLANT	○	○
ASTHMA	○	○	SCARLET FEVER, RHEUMATIC HEART DISEASE	○	○	EXCESSIVE BLEEDING OR BRUISING	○	○
HEPATITIS A, B OR C	○	○	LATEX OR NICKEL SENSITIVITY/ALLERGY	○	○	DRUG OR ALCOHOL DEPENDENCY	○	○
TONSILLITIS	○	○	HIGH OR LOW BLOOD PRESSURE	○	○	TONSILS/ADENOIDS REMOVED	○	○
HEART DEFECT, HEART MURMUR, HEART DISEASES	○	○	AIDS, HIV POSITIVE	○	○	SMOKING / TOBACCO USE	○	○

ALLERGIES (MEDICINE OR OTHER)
○ Yes ○ No If yes, please list

DO YOU NOW OR HAVE YOU EVER TAKEN BISPHOSPHONATES, INCLUDING FOSAMAX, DIDRONEL, BONIVA, AREDIA, ACTONEL, SKELID, OR ZOMETA?
○ Yes ○ No If so, which drug

DO YOU HAVE ANY HEALTH ISSUES NOT LISTED THAT YOU THINK WE SHOULD KNOW ABOUT? PLEASE EXPLAIN:

HAVE YOU BEEN HOSPITALIZED FOR ANY SURGICAL PROCEDURE OR SERIOUS ILLNESS?	ARE YOU PREGNANT? (FEMALE PATIENT)
○ Yes ○ No	○ Yes ○ No

ARE YOU TAKING ANY MEDICATION AT THIS TIME?	NAME OF YOUR PHYSICIAN	PHONE
○ Yes ○ No If yes, please list:		

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME	ADDRESS

INSURANCE COMPANY PHONE	GROUP/PLAN NUMBER	PRIMARY POLICY HOLDER NAME

EMPLOYER	SOCIAL SECURITY NUMBER	DATE OF BIRTH

SECONDARY INSURANCE COMPANY NAME	ADDRESS

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ADULT HEALTH HISTORY FORM

INSURANCE COMPANY PHONE	GROUP/PLAN NUMBER	SECONDARY POLICY HOLDER NAME
EMPLOYER	SOCIAL SECURITY NUMBER	DATE OF BIRTH

DO YOU PARTICIPATE IN A FLEX PLAN?
○ Yes ○ No

I authorize release of any information relating to this claim and understand I am responsible for all cost of dental treatment.

SIGNATURE

I hereby authorize payment directly to the dentist of the insurance benefits otherwise payable to me.

SIGNATURE

DENTAL HEALTH INFORMATION

ARE YOU EXPERIENCING ANY DENTAL PROBLEMS? ○ Yes ○ No	DATE OF LAST DENTAL VISIT	ANY TREATMENT NEEDED?
HOW OFTEN DO YOU BRUSH AND FLOSS EACH DAY? Brushes ____ times per day Flosses ____ times per day	DENTIST	PHONE

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING HEALTH ISSUES?

	YES	NO		YES	NO		YES	NO
JAW PAIN (JOINT, EAR, SIDE OF FACE)	○	○	SNORING / SLEEP APNEA / C-PAP	○	○	DIFFICULTY CHEWING	○	○
HEAD/NECK, JAW OR TOOTH INJURY	○	○	FEAR OF DENTAL TREATMENT	○	○	MISSING PERMANENT TEETH	○	○
CLICKING OR POPPING OF THE JAW JOINTS	○	○	TOOTH SENSITIVITY TO HEAT, COLD OR SWEETS	○	○	PREVIOUS ORTHODONTIC TREATMENT	○	○
CLENCHING OR GRINDING	○	○	SORE OR BLEEDING GUMS	○	○	TONGUE THRUST	○	○

TREATMENT AUTHORIZATION

I have read and I understand the above questions. I will not hold my orthodontist or any member of the staff responsible for any errors or omissions that I have made in the completion of this form.

I also understand this information will be held in the strictest confidence and that it is my responsibility to inform this office of any later changes to this history record or medical / dental status.

We may discuss your treatment with referring doctor / dentist for the furtherment of your treatment.

SIGNATURE | PRINT PATIENT NAME | DATE

You can submit the file by emailing the file to admin@craigandstreight.com or print it and bring it with you to your initial consultation.
By sending this form via email, I'm aware that information are not encrypted. I understand the risks of unencrypted email.