Adult Health History

NAME:	YOUR OCCUPATION:
ADDRESS:	BUS. ADDRESS:
CITY: ZIP:	BUS. PHONE: BUS. FAX: BUS. E-MAIL:
PHONE #: FAX: E-MAIL:	CELL PHONE:
D.O.B.: AGE: MALE/FEMALE ☐ ☐	SPOUSE'S NAME: SPOUSE'S OCCUPATION:
MARITAL STATUS:	BUS. ADDRESS:
PARTY RESPONSIBLE FOR ACCT.:	BUS. PHONE: BUS. FAX: BUS. E-MAIL:
REFERRED TO THIS OFFICE BY:	CELL PHONE:
WHAT IS YOUR REASON FOR SEEKING AN ORTHODONTIC EVALUATION?	
SPECIAL MEDICAL ALERT - *For office use only*	

PERSONAL INFORMATION

1. Do you have any special hobbies or interests? ❒ Yes ❒ No
   Please describe: _____
2. Do you have any children? (list names, ages, and sex) _____

DENTAL

DENTIST'S NAME: _____

ADDRESS: _____ **PHONE:** _____

Have you:

1. A fear of dentists? ❒ Yes ❒ No
2. Noticed yourself clenching or grinding your teeth? ❒ Yes ❒ No
3. Ever had pain when opening or closing your mouth? ❒ Yes ❒ No
4. Trouble with bad breath or bad taste in your mouth? ❒ Yes ❒ No
5. A history of "Cold sores" or acutely sore mouth? ❒ Yes ❒ No
6. A history of soreness of jaw muscle or jaw joint? ❒ Yes ❒ No
7. A history of previous orthodontic therapy? ❒ Yes ❒ No
8. Had traumatic injury to the head or face? ❒ Yes ❒ No

Are you experiencing:

9. Discomfort with your teeth? ❒ Yes ❒ No
10. Sensitivity to hot/cold? ❒ Yes ❒ No
11. Bleeding gums/sore gums? ❒ Yes ❒ No
12. Bite shifting/looseness? ❒ Yes ❒ No
13. Self-conscious about certain facial features? ❒ Yes ❒ No
14. Self-conscious about the appearance of your teeth? ❒ Yes ❒ No
15. Any discomfort or unusual changes in the soft tissue of the mouth? ❒ Yes ❒ No

If yes was answered to any of the above, please explain: _____

MEDICAL

PHYSICIAN'S NAME: _____

ADDRESS: _____ **PHONE:** _____

Are you:

1. Under physicians care? ❒ Yes ❒ No
2. Taking medication? ❒ Yes ❒ No

Do you have any history of:

3. Hospitalizations? ❒ Yes ❒ No
4. Rheumatic Fever, Heart Disease, or Heart Murmur? ❒ Yes ❒ No
5. Respiratory problems? ❒ Yes ❒ No
6. Mouth breathing? ❒ Yes ❒ No
7. Prolonged bleeding? ❒ Yes ❒ No
8. Diabetes? ❒ Yes ❒ No
9. Joints often painful or swollen? ❒ Yes ❒ No
10. Anemia? ❒ Yes ❒ No
11. Epilepsy? ❒ Yes ❒ No
12. Thyroid or Hormone Therapy? ❒ Yes ❒ No
13. Severe headaches? ❒ Yes ❒ No
14. Pains of face or head? ❒ Yes ❒ No
15. Tumors or Cancer? ❒ Yes ❒ No
16. Syphilis or Gonorrhea? ❒ Yes ❒ No
17. Receiving x-ray or radioactive isotope treatment? ❒ Yes ❒ No
18. Yellow jaundice or Hepatitis, AIDS, Herpes or other immuno-suppressive disorders? ❒ Yes ❒ No
19. Allergies (i.e., aspirin, penicillin, Novocain, etc.)? ❒ Yes ❒ No

    _____

20. Are there any special medical conditions of which we should be aware? ❒ Yes ❒ No
    Please describe : _____

If yes was answered to any of the above, please explain: _____

WOMEN

1. Are you pregnant now? ❒ Yes ❒ No
2. Are you taking birth control pills? ❒ Yes ❒ No

OTHER

1. Do you take multiple vitamins? ❒ Yes ❒ No
2. Do you smoke more than two packages of cigarettes per week? ❒ Yes ❒ No

I give permission to release any pertinent information to any involved insurance companies or medical/dental professionals.
To the best of my knowledge, the above statements are true and accurate. I agree to inform this office of any changes in the status of my health.

Signature: _____ *Date:* _____

Matthew J. Busch, D.D.S.,
PRACTICE LIMITED TO ORTHDONTICS
AND DENTOFACIAL ORTHOPEDICS

1701 East Woodfield Road, Suite 500
Schaumburg, Illinois 60173

847-517-1333

Visit us at www.BORNTOSMILE.com

"Form & Function Through Art, Science & ***Teamwork***"

Matthew J. Busch, D.D.S., Ltd.

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of Matthew J. Busch, D.D.S., Ltd. I hereby authorize, as indicated by my signature below, Matthew J. Busch, D.D.S., Ltd. to use and to disclose my protected health information for any necessary clinical, financial, and insurance purposes.

_____ _____
Print Name Address

_____ _____
Signature Date

Please check your preferred means of communication:

☐ You may contact me at my home telephone number _____

☐ You may contact me on my mobile telephone number _____

☐ You may contact me on my work telephone number _____

☐ You may send me an unencrypted email/text message at: _____

☐ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date Added / Removed: _____

2. _____ Date Added / Removed: _____

3. _____ Date Added / Removed: _____

4. _____ Date Added / Removed: _____

For Office Use Only:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (Please Specify) _____

Staff Person Initials _____

Matthew J. Busch, D.D.S., Ltd.

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Through
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Special Authorization

for patient privacy protection

Matthew J. Busch, D.D.S., Ltd.

I, _____, consent to allow Matthew J. Busch, D.D.S., Ltd.
to use **my / my son's / my daughter's** (check one):

- ☑ dental / medical photos
- ☑ radiographs
- ☑ study models
- ☑ TMJ score
- ☑ and other information (please describe): _____

from **my**/ **my son's / my daughter's** dental record for (check one):

- ☑ In-office Born to Smile board / In-office Digital Display Board
- ☑ website marketing/social media
- ☑ scientific papers
- ☑ lectures
- ☑ demonstrations and other educational events
- ☑ other (please describe): _____

I have been informed that I am not required to sign this consent.

I understand I am not financially compensated for this authorization.

This consent may be revoked by written notice delivered to Matthew J. Busch, D.D.S., Ltd. within 30 days of signature.

Matthew J. Busch, D.D.S., Ltd.
Name of Practice

_____
Patient Date

By: _____
Authorized Staff Member Date

_____
Print Patient Name

_____
Guardian / Parent Date

Please Note: Dr. Busch is on the faculty of the University of Pennsylvania School of Dental Medicine and may use treatment plans with before & after photographs in his presentations to the orthodontic residents for teaching purposes.