ROBERT W. SHAFER, DMD, MS
HEALTH HISTORY FORM

Welcome to Our Office!

Patient's Name:________________________ Age:__________ Birth date:________________

Name you like to be called:________________ School:______________________________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Address:______________________________ City:____________ State:______ Zip:________

Patient's E-Mail address:____

Who may we thank for referring you to our office? ______________________________

Have we treated any other family members? Name:________________________________

Have you attended the following events hosted by Shafer Smiles?
(*please check all that apply)*

☐Swim Party ☐School Programs ☐Sport/Team Events ☐Other

RESPONSIBLE PARTY INFORMATION

Name:____ Marital Status________________

Address:______________________________ City:____________ State:______ Zip:________

How long at this address:____________ E-Mail Address:______________________________

Social Security #:______________ Birth date:____________ Relationship to Patient:____________

Employer: ____________________ Occupation: __________No. of years Employed: ____________

Name:____Marital Status________________

Address:______________________________ City:____________ State:______ Zip:________

How long at this address:____________ E-Mail Address:______________________________

Social Security #:______________ Birth date:____________ Relationship to Patient:____________

Employer:____________________ Occupation:__________No. of yrs. Employed:____________

INSURANCE INFORMATION

Insured Name:____________________ Insured SS#:____________ Insurance Co:____________

Insurance Co: Address:__________________________________ Group #:______________

Phone:________________________ Insured's Employer:______________________________

Do you have dual coverage? ☐Yes ☐No ***If Yes:***

Insured Name:____________________ Insured SS#:____________ Insurance Co:____________

Insurance Co: Address:__________________________________ Group #:______________

Phone:________________________ Insured's Employer:______________________________

EMERGENCY INFORMATION

Emergency Contact:____

Contact's Address:________________________City:______________State:_____Zip:________

Home Phone:______________________ Relationship to Patient:________________________

Continued on Reverse Side

All past medical and dental history may be important for your optimal care. Please take the time to be as accurate as possible in answering the following questions. Thank you.

A. Please list your chief concerns for treatment (in order of priority):

____

B. What or who motivated you to seek treatment and what do you expect?

____

C. Describe anything that bothers you about the appearance of your teeth, smile or face:

____

MEDICAL/DENTAL HISTORY

Physician's Name:____ Phone:______________________________

Dentist's Name:____ Phone:______________________________

☐Yes ☐No Do you have pain, clicking, and/or popping noises in the jaw?

☐Yes ☐No Do you have difficulty breathing through the nose?

☐Yes ☐No Do you have habits such as nail biting, finger/thumb sucking, tongue thrust, clenching or grinding? *(circle)*

☐Yes ☐No Do you have speech problems or are you in speech therapy?

☐Yes ☐No Have you had your tonsils and/or adenoids removed?

☐Yes ☐No Has there been any history of: ☐Artificial joints/valves ☐Asthma ☐TB ☐Aids/HIV

☐Yes ☐No ☐Kidney problems ☐Liver condition ☐Epilepsy ☐Rheumatic Fever ☐Diabetes ☐Cancer ☐Hepatitis ☐Do you bleed easily? ☐Other major illness:______________________________

☐Yes ☐No Do you have any of the following allergies: ☐Sulfur ☐Penicillin ☐Latex ☐Nickel/metals ☐Other

☐Yes ☐No Are you currently taking any medication? List: ____

☐Yes ☐No Do you have a heart condition? *If so, do you pre-medicate*? _______ *Cardiologist:* ________________

☐Yes ☐No Do you have sleep apnea?

☐Yes ☐No Have there been any injuries to the teeth, face or chin? Please specify: ___________________________

☐Yes ☐No Do you play a musical instrument? ____

RELEASE

I authorize Dr. Robert W. Shafer and his team of health care professionals to perform diagnostic procedures and treatment as may be necessary for proper orthodontic care. I authorize the release of any information concerning my child's health care for advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I authorize the release of any information concerning my child's health care for advice and treatment or my general dentist or dental care specialists that may be involved in my child's treatment. I authorize the taking of photographs, x-rays and other diagnostic records before, during and after treatment and to the use of the same by the doctor in scientific presentations, scientific literature, web page information and upon request a hard copy of digital images may be created to have viewed by an outside certified healthcare professional for a fee.

I have received and acknowledged the privacy policy concerning my child's health care.

I understand where appropriate a credit report may be obtained.

Date:_______________ Signature:____

Updated On:_________ Signature:____

Updated On:_________ Signature:____