Dr. Lucy DeGuzman DDS MS
1029 Refugee Road Ste. 400 Pickerington, Ohio 43147
(614)759-4446

DeGuzman Orthodontics
3843 Trueman Court Hilliard 43026
(614) 527-8555

ADULT PATIENT INFORMATION CONFIDENTIAL

WELCOME! Date: _____

Name: _____ Age: _____ Sex: ____ I prefer to be called:_____
Last First Middle

Address: _____
Street City State Zip

Birthdate: _____ Status: single married divorced widowed separated

Home #: _____ Cell #: _____ Email: _____

Best no. to call for appointments: _____ Best time to call: _____

In case of an emergency, call: _____ Relationship_____ Phone #: _____

Employer: _____ Occupation: _____

Business address: _____
Street city state zip

How long there? _____

Spouse name: _____ Employer:_____ Work phone:_____

How did you hear about us? _____

Other members of the family seen by us: _____

RESPONSIBLE PARTY

Name of person responsible for this account: _____ Relationship: _____

Address: _____
Street city state zip

Home phone: _____ Soc. Sec. #: _____ Birthdate: _____

Driver's license #:_____ Employer: _____ Work phone:_____

INSURANCE INFORMATION

Name of Insured: _____Relationship: _____Birthdate: _____

Soc Sec #:_____ Employer: _____ Date employed:_____

Insurance company: _____ Ins co address: _____

Group Policy #_____ Ins co phone #_____ Max annual benefit: _____

Do you have secondary insurance? If yes, complete the following:

Name of Insured: _____Relationship: _____Birthdate: _____

Soc Sec #:_____ Employer: _____ Date employed:_____

Insurance company: _____ Ins co address: _____

Group Policy #_____ Ins co phone #_____ Max annual benefit: _____

MEDICAL HISTORY

Do you or have you ever had any of the following:

Y	N	High or Low Blood Pressure	Y	N	Cancer	Y	N	Fainting/ Seizures/Epilepsy
Y	N	Heart Attack	Y	N	Hepatitis	Y	N	Diabetes
Y	N	Rheumatic Fever	Y	N	Eating Disorder	Y	N	Any Stays in Hospital
Y	N	Heart Murmur	Y	N	Kidney/Liver Disease	Y	N	Prosthesis
Y	N	Mitral Valve Prolapse	Y	N	Ulcers/Colitis	Y	N	Stroke
Y	N	Congenital Heart Defect	Y	N	Tuberculosis	Y	N	Radiation Therapy
Y	N	Heart Surgery/Pacemaker	Y	N	Shingles	Y	N	Thyroid Problem
Y	N	Bone Fracture, any major accident	Y	N	Venereal Disease	Y	N	Emphysema
Y	N	Anemia/Bleeding Disorder	Y	N	Asthma	Y	N	AIDS or HIV Positive

Allergies or reactions to any of the following:

Y	N	Dental Anesthetics	Y	N	Penicillin	Y	N	Metals (jewelry/clothing snaps)
Y	N	Aspirin	Y	N	Sulfa Drugs	Y	N	Latex (gloves/balloons)
Y	N	Ibuprofen	Y	N	Codeine	Y	N	Vinyl
Y	N	Acrylic	Y	N	Other Substances (specify) _____			

Y N Are you under medical treatment now? If yes, why? _____
Y N Are you taking Bisphosphonates? (ie. Fosamax, Actonel, Boniva,) If yes, for how long now?_____
Y N Are you taking medications? If yes, please list _____
Y N Do you use tobacco?
Y N Any Operations? If yes, what? _____

WOMEN ONLY
Y N Are you pregnant?
Y N Are you nursing?

DENTAL HISTORY
Dentist _____ Phone _____ Address _____Last Visit _____

What is the reason for your visit today? _____
Y N Previous orthodontic treatment? If yes, when _____
Doctor's name and address _____
Y N Have you ever been treated for periodontal disease (gum disease)? If yes, describe_____
Y N Have there been any injuries to the mouth or teeth? If yes, describe_____
Y N Have you ever had any injury to the head and neck area? If yes, describe_____
Y N Do you clench or grind your teeth?
Y N Clicking of jaw joints? Y N Pain in the jaw, ear, joint or side of face?
Y N Difficulty in opening or closing? Y N Locking of jaw?

Do you have any of the following habits?
Y N Finger/Thumbsucking
Y N Lip Biting
Y N Nail Biting

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. If there are any changes later to this history records, or medical/dental status, it is my responsibility to inform this office. I also give my permission for a clinical examination and necessary x-rays.

SIGNED _____ DATE_____
Patient

SIGNED _____ DATE_____
Doctor

Medical History Update Date _____Dr Signature _____ Comments_____

Date _____ Dr Signature _____ Comments_____