CRANFORD ORTHODONTICS
Alexander D. Cranford DMD, MS
91 JEFFERSON PARKWAY, SUITE B
NEWNAN GA 30263
OFFICE (770) 251-4444

Adult Patient Health History Form

All sections must be complete prior to submitting.

Patient Information

Date

Patient First, Middle and Last Name

Preferred Name

Email

Preferred Phone #

Phone Type? ○ Mobile ○ Home ○ Other

Address

City

State

Zip

Birth Date

Age

Gender

Marital Status

Whom may we thank for recommending our services

Names and Ages of Children in Family

☐ Not Applicable

Name | Age | Have been seen in our office? (Yes/No)

Name | Age | Have been seen in our office? (Yes/No)

Name | Age | Have been seen in our office? (Yes/No)

Name | Age | Have been seen in our office? (Yes/No)

Responsible Party Information

☐ Not Applicable

Last Name

First Name

Middle Name

Preferred Name

Address

City | State | Zip

Home Phone | Cell Phone | Work Phone

Relationship to Patient

Employer | Occupation | Number of Years Employed

Spouse Information

☐ Not Applicable

Spouse's Name | Preferred Name

Relationship to Patient | Employer | Occupation

Birth Date | Work Phone | Cell Phone

Emergency Information

Name of nearest relative (not living with you)

Phone Number(s) | Relationship to Patient

Dental Insurance

Primary Insurance ***(if insured's address is different than responsible party, please inform our office)***

☐ Not Applicable

Do you have Insurance coverage for dentistry?

○ Yes
○ No
○ Unsure

Do you have Insurance coverage for orthodontic treatment?

○ Yes
○ No
○ Unsure

Insured's Full Name | Insured's Birth Date

Member ID or Social Security # | Relationship to Patient

Insurance Company | Phone # for Provider Services

Group #

Insured's Employer

Secondary Insurance ***(if insured's address is different than responsible party, please inform our office)***

☐ Not Applicable

Do you have Insurance coverage for dentistry?

- ○ Yes
- ○ No
- ○ Unsure

Do you have Insurance coverage for orthodontic treatment?

- ○ Yes
- ○ No
- ○ Unsure

Insured's Full Name

Insured's Birth Date

Member ID or Social Security #

Relationship to Patient

Insurance Company

Phone # for Provider Services

Group #

Insured's Employer

Fee Expectations

If treatment is recommended for you, what is your ideal DOWN payment?

- ○ $350 - $499
- ○ $500 - $749
- ○ $750 +
- ○ I would like to pay in full and receive a courtesy discount
- ○ I have an HSA or FSA I would like to use

If treatment is recommended for you, what is your ideal MONTHLY payment?

- ○ $100 - $199
- ○ $200 - $299
- ○ $300 - $399
- ○ I have an HSA or FSA I would like to use

If treatment is recommended for you, what is your desired time frame to begin this exciting journey?

- ○ I would like to get started today
- ○ I would like to get on the schedule
- ○ I am shopping around for other opinions
- ○ I am unsure

Health Questionnaire

Patient's Physician

Address

Physician's phone number

Date of most recent physical exam

General Questions

What concerns you about your teeth and jaws?

Other family members with similar condition?

Who suggested that you might need orthodontic treatment?

Have you ever had any previous orthodontic treatment or consultation?

Why did you select our office?

List interests and hobbies

NOW OR IN THE PAST HAS THE PATIENT HAD:

Diabetes	○ Yes ○ No	Tuberculosis	○ Yes ○ No	Endocrine or Thyroid	○ Yes ○ No
Asthma	○ Yes ○ No	Anemia	○ Yes ○ No	Prolonged Bleeding	○ Yes ○ No
Cancer	○ Yes ○ No	Epilepsy/Seizure	○ Yes ○ No	Hay Fever	○ Yes ○ No
Gastrointestinal Disorders	○ Yes ○ No	Herpes	○ Yes ○ No	Handicap/Disability	○ Yes ○ No
Radiation/Chemotherapy	○ Yes ○ No	Sickle Cell	○ Yes ○ No	Hearing Impairment	○ Yes ○ No
Mitral Valve Prolapse	○ Yes ○ No	Stroke	○ Yes ○ No	Sinus Problems	○ Yes ○ No
Ulcers	○ Yes ○ No	Drug Problems	○ Yes ○ No	Liver Involvement	○ Yes ○ No
Rheumatic Fever	○ Yes ○ No	HIV/AIDS	○ Yes ○ No	Fainting or Dizziness	○ Yes ○ No
Bone Disorders	○ Yes ○ No	Hepatitis	○ Yes ○ No	Nervous Disorders	○ Yes ○ No
Sleep Apnea	○ Yes ○ No	Heart Defect, Murmur	○ Yes ○ No	Kidney Involvement	○ Yes ○ No
Birth/Hereditary Problems	○ Yes ○ No	Immune System Problems	○ Yes ○ No	History of Eating Disorders	○ Yes ○ No
Arthritis or Joint Problems	○ Yes ○ No	Depression/Mental Health	○ Yes ○ No	High Blood Pressure	○ Yes ○ No
Low Blood Pressure	○ Yes ○ No	Heart disease, Heart attack	○ Yes ○ No	Skin Disorder	○ Yes ○ No

Do you smoke or chew tobacco?

Do you take antibiotic pre-medication prior to dental visits?

Has the patient ever taken medication to strengthen their bones?

List any drugs, medications, nutritional supplements now being taken and give reasons

Any medical, dental, or surgical problems not covered above?

Women: Are you pregnant?

Are you trying to become pregnant?

Allergies

Do you have allergies to the following

Latex
- ○ Yes
- ○ No

Erythromycin
- ○ Yes
- ○ No

Penicillin
- ○ Yes
- ○ No

Codeine
- ○ Yes
- ○ No

Nickel or other metals
- ○ Yes
- ○ No

Tetracycline
- ○ Yes
- ○ No

Dental Anesthetics
- ○ Yes
- ○ No

Aspirin
- ○ Yes
- ○ No

Acrylics
- ○ Yes
- ○ No

Other allergies not listed

Dental History

Patient's Dentist

Reason for Last Visit

How often does the patient have dental check-ups?

Teeth Grinding or Clenching?

Past/Present Injuries To the face, mouth, or teeth?

Missing or extra permanent teeth?

Clicking or discomfort in jaw joints near ears?

treated for "TMJ" or "TMD"?

To the best of my knowledge, the health information is complete and correct. I will not hold Cranford Orthodontics responsible for any errors or omissions that I have made in completing this form. I will notify Cranford Orthodontics of any changes in my medical or dental health. I understand that where appropriate, credit bureau reports may be obtained. I have also received a copy and read the notice of privacy practices.

Date

Signature of Patient or Parent if Patient is a Minor

Thank you for completing the above information. Please only click the "Submit" button once, as it may take a few moments to process. Once successfully submitted, you will be redirected back to the previous page and a confirmation message will appear.