LEGACY ORTHODONTICS

"Creating beautiful smiles with personalized care"

CONFIDENTIAL
MEDICAL/DENTAL HISTORY FORM – ADULT

Date: _____

PATIENT INFORMATION

Patient's Name: _____ I Prefer to be called:_____
Last First Middle

Birth Date:_____ Age:_____ Sex: Male Female

Home Phone No._____

Dentist:_____

Cell Phone No. _____

Phone No:_____

e-mail address: _____

Physician:_____

Phone No:_____

Referred by:_____

DENTAL HISTORY

Date of last dental care:_____ Family history of orthodontic problems?: _____

Were there any habits which have caused the teeth to move?(i.e. nail or lip biting, thumbsucking, etc.)? _____

Has an orthodontist been consulted previously?_____

What is your main concern? _____

_____

Any injuries to face, mouth, or teeth in the past? YES NO

Do you have any speech problems? YES NO

Are there any missing or extra permanent teeth? YES NO

Do you have clenching or grinding habits? YES NO

List any musical instruments played by mouth: _____

_____

Do you have sore or sensitive teeth? YES NO

Have you ever had any orthodontic treatment? YES NO

Are you self-conscious about the appearance of your teeth? YES NO

Has a dentist shown you how to clean his/her teeth? YES NO

How often do you brush your teeth (per day)?_____

List type of toothbrush (hard, med., soft)_____

List any other aids (floss, stimulant, water spray device, rubber tip, toothpick) and how often used:_____

When was the last professional dental cleaning?_____

How often scheduled?_____

Additional general dental information:_____

_____

_____

Are you currently taking or have ever taken any intravenous bisphosphonates for serious bone disorders/cancers; such as Zometa (alendronate), Aredia (pamidronate), Didronel (etidronate). Yes No if yes, describe: _____

_____

_____

Are you currently taking or have ever taken any oral bisphosphonates for osteoporosis, osteopenia or other uses: such as, Fosamax (alendronate), Actonel (risendronate), Boniva (ibandronate), Skelid (tiludronate), Didronel (etidronate). YES NO If yes, describe: _____

_____

_____

Please complete the back of this form

MEDICAL HISTORY

Date of last medical care/physical: _____

Have you been hospitalized in the last 2 years? YES NO If yes, reason: _____

Your health is: Excellent Good Fair Poor

For the following, please circle YES or NO. Please describe any YES answers below under Remarks.

1. Allergies			8. Fainting	YES	NO
a. Penicillin	YES	NO	9. Glandular disease (thyroid, etc.)	YES	NO
b. Other Antibiotics	YES	NO	10. Heart disease	YES	NO
c. Local Anesthetics	YES	NO	11. Heart murmur	YES	NO
d. Metals	YES	NO	12. Rheumatic fever	YES	NO
e. Vinyl	YES	NO	13. High blood pressure	YES	NO
f. Latex (gloves, balloons)	YES	NO	14. Low blood pressure	YES	NO
g. Acrylic	YES	NO	15. Kidney disease	YES	NO
h. Others_____	YES	NO	16. Liver disease, Hepatitis, Jaundice	YES	NO
2. Arthritis	YES	NO	17. Psychiatric treatment	YES	NO
3. Asthma	YES	NO	18. Radiation treatment	YES	NO
4. Blood disease or Abnormal Bleeding Problems	YES	NO	19. Respiratory disease	YES	NO
a. Anemia	YES	NO	20. Stomach or Duodenal ulcers	YES	NO
b. Clotting Problems	YES	NO	21. Tumor history	YES	NO
c. Other Blood Disorders_____	YES	NO	22. Venereal disease	YES	NO
5. Diabetes	YES	NO	23. A.I.D.S/HIV +	YES	NO
a. Immediate family history?	YES	NO	24. Other Medical Conditions _____		
b. Urinates frequently?	YES	NO	_____		
c. Often thirsty?	YES	NO	25. Emotional/Behavioral problems _____		
6. Chest pains, ankle swelling, or shortness of breath?	YES	NO	_____		
7. Epilepsy	YES	NO			

26. Do you chew or smoke tobacco? YES NO
27. Have you had excessive bleeding requiring treatment? YES NO
28. Are you taking medications, nutrient supplements, drugs or pills regularly? YES NO If yes, please name:_____

_____

29. Has patient experienced any unfavorable reaction to previous dental treatment? YES NO
30. Does patient require pre-medication, based on physician instruction/personal reference, prior to dental treatment? YES NO

If yes, name of medication _____

31. Is there any other information we should know?_____
32. Women only:
    a. Are you pregnant? YES NO
    b. Are you anticipating becoming pregnant? YES NO

REMARKS _____

_____

I have read and understand the above questions. I will not hold my orthodontist, at Legacy Orthodontics, or any member of their staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice. I authorize Legacy Orthodontics to take x-rays, study models and photographs as diagnostic aids to make a thorough diagnosis of the patient's orthodontic needs.

Signed: _____ Date: _____
(Patient)

Signed: _____ Date: _____
(Doctor)