

Medical Dental History Form for Adult Patients

PATIENTS

Date _____
 Patient's last name _____ First name _____ Middle initial _____
 Title Mr. Mrs. Miss Dr. Other _____ I prefer to be called _____
 Birth date _____ Sex Male Female Social Security# _____
 Marital Status Single Married Separated Divorced Widowed
 Home address _____ City, State, Zip code _____
 Home phone () _____ Cell phone () _____ Work phone () _____
 Email Address(es) _____
 Occupation _____ Employer _____

CLOSEST RELATIVE

Spouse or closest relatives name(s) _____
 Title Mr. Mrs. Miss Dr. Other _____ Relationship to patient _____
 Address (if different than patient address) _____
 Home Phone (if different) () _____ Cell phone () _____ Work phone () _____

DENTIST

Patient's Dentist _____ Address, City, State _____
 Last seen _____ Reason _____ Next appointment _____
 Other dentist/dental specialists now being seen: Name _____ City, State _____
 Reason _____

PHYSICIAN

Patient's Physician _____ City, State _____
 Last seen _____ Reason _____ Next appointment _____
 Most recent physical exam _____

Other physicians/health care providers being seen now:

Name _____ City, State _____
 Reason _____
 Name _____ City, State _____
 Reason _____

GENERAL INFORMATION

What concerns you about your teeth? _____

Who suggested that you might need orthodontic treatment? _____

Why did you select our office? _____

Have you had any previous orthodontic treatment? Please describe? _____

Have any other family members been treated in this office? Please name them. _____

Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain. _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____

Address (if different than patient address) _____

Home Phone (if different) () _____ Cell phone () _____ Email address(es) _____

Social Security # _____ Employer _____

DENTAL INSURANCE

Primary policy holder's full name _____ Birth date _____

Social Security # _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID# _____

Does this policy have orthodontic benefits? Yes No Don't Know _____

Secondary policy holder's full name _____ Birth date _____

Social Security # _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID# _____

Does this policy have orthodontic benefits? Yes No Don't Know _____

MEDICAL INSURANCE

Policy holder's full name _____

Insurance Company _____

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation.

For the following questions, please mark yes, no or don't know/understand (dk/u).

MEDICAL HISTORY

Now or in the past, have you had:

- | Yes | No | DK/U | |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Birth defects or hereditary problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bone fractures or major injuries? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Any injuries to face, head, neck? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis or joint problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Endocrine or thyroid problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes or low sugar? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Kidney problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cancer, tumor, radiation treatment or chemotherapy? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stomach ulcer, hyperacidity, acid reflux? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Immune system problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | History of osteoporosis? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gonorrhea, syphilis, herpes, sexually transmitted diseases? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | AIDS or HIV positive? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis, jaundice, or other liver problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Polio, mononucleosis, tuberculosis, pneumonia? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Seizures, fainting spells, neurologic problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mental health disturbance or depression? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vision, hearing, or speech problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | History of eating disorder (anorexia, bulimia)? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High or low blood pressure? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excessive bleeding or bruising, anemia? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chest pain, shortness of breath, tire easily, swollen ankles? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart defects, heart murmur, rheumatic heart disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Angina, arteriosclerosis, stroke or heart attack? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Skin disorder (other than common acne)? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you eat a well-balanced diet? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent headaches or migraines? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent ear infections, colds, throat infections? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asthma, sinus problems, hayfever? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tonsil or adenoid condition? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you frequently breathe through your mouth? |

Have you had allergies or reactions to any of the following?

- | Yes | No | DK/U | |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Local anesthetics (novocaine, lidocaine, xylocaine) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Latex (gloves, balloons) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Metals (jewelry, clothing snaps) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other antibiotics |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ibuprofen (Motrin, Advil) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Acrylics |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Plant pollens |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Animals |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Foods |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other substances _____ |

DENTAL HISTORY

Now or in the past, have you had:

- | Yes | No | DK/U | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Permanent or extra (supernumerary) teeth removed? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Supernumerary (extra) or congenitally missing teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chipped or injured primary or permanent teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Any sensitive or sore teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bleeding gums, bad taste or mouth odor? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Jaw fractures, cysts, infections? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Any teeth treated with root canals or pulpotomies? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | "Gum boils," frequent canker sores or cold sores? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | History of speech problems or speech therapy? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty breathing through nose? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Food impaction between the teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mouth breathing habit or snoring at night? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent oral habits (sucking finger, chewing pen, etc)? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Teeth causing irritation to lip, cheek or gums? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal swallowing (tongue thrust)? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tooth grinding or clenching? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Clicking, locking in jaw joints? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Soreness in jaw muscles or face muscles? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ringing in ears, difficulty in chewing or opening jaw? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been treated for "TMJ" or "TMD" problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Any broken or missing fillings? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Any serious trouble associated with previous dental treatment? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been diagnosed with gum disease or pyorrhea? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had an orthodontic consultation or treatment before now? |

PATIENT HEALTH INFORMATION

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements, that you take.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Have you ever taken any medications to strengthen your bones? Please describe. _____

Do you or have you ever had a substance abuse problem? _____

Do you chew or smoke tobacco? _____

Have you noticed any changes in your face or jaws? _____

Any other physical problems? _____

How often do you brush? _____ How often do you floss? _____

Women: Are you pregnant? Yes No

Are you trying to become pregnant? Yes No

FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders _____ Diabetes _____

Arthritis _____ Severe allergies _____

Unusual dental problems _____ Jaw size imbalance _____

Other family medical conditions? _____

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature _____ Date _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature _____ Date _____

MEDICAL HISTORY UPDATES OR CHANGES

Changes _____

Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Signature _____ Date _____

Dental Staff Signature _____ Date _____