

Medical/Dental History - Adult

Date: _____

Patient's Name: _____ Sex: _____ Age: _____ Birthdate: _____

Prefers to be addressed by: _____ Referred by: _____

Address: _____ City: _____ Zip: _____ Phone: _____

Employed by: _____ Occupation: _____ Work Phone: _____

Marital Status: Married Single Divorced Separated Widowed

Spouse's Name: _____ Occupation: _____ Work Phone: _____

Employed by: _____ Child's Name: _____ Child's Name: _____
DOB: _____ DOB: _____

Person Responsible for Account:
 Self Spouse Other: _____ SS#: _____

Address: _____ Business Phone: _____ Home Phone: _____

DENTAL INSURANCE

Primary Insurance Co: _____ Gr. #: _____ Ortho Coverage: Yes No

Insured's Name: _____ SS#: _____ Birthdate: _____

Secondary Insurance Co: _____ Gr. #: _____ Ortho Coverage: Yes No

Insured's Name: _____ SS#: _____ Birthdate: _____

Other Insurance Information: _____

DENTAL HISTORY

Patient's Dentist: _____ Date of Last Visit: _____

1. Have there been any injuries to the face, mouth or teeth? YES NO

2. Have you had or do you presently have any of the following habits?
 NO Thumb or finger sucking Lip Biting Snoring
 Grinding of teeth at night Mouth breathing

3. Have you been informed of any missing or extra permanent teeth? YES NO

4. Are you aware of sores, lumps or irritated areas in the mouth? YES NO

5. Has an orthodontist been consulted previously? YES NO
Name: _____ Date: _____

6. Have you ever been treated for: Bad Bite TMJ Periodontal disease
If so, by whom?: _____ NO

7. Do you have any speech problems? YES NO

8. Are you frightened or anxious about Orthodontic treatment? YES NO

9. Are you concerned about the appearance of your teeth? YES NO

10. Is there anything you would like to change about your smile?
If so, what: _____ YES NO

11. What aspect of dental treatment are you most concerned with? Quality Cost Discomfort Time

12. Reason for consultation (chief concern): _____

13. Has there ever been any orthodontic treatment for any other member of your family? YES NO
Were they satisfied with the results? YES NO Stage of TX: _____

Sons (Dr. _____) Daughters (Dr. _____) Brothers (Dr. _____) Sisters (Dr. _____)

MEDICAL HISTORY

COMMENTS:

1.	Is the patient's general health good at this time	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
2.	What is the name of the family physician?	Date of last physical: _____		
3.	Is the patient under the care of a physician at this time? Explain: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
4.	Is the patient taking any medication? Name: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
5.	Is the patient allergic to any medication? (Penicillin, Sulfa, etc.) Name: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
6.	Has the patient ever taken any diet medication? (Fen-Phen)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
7.	Has the patient had tonsils and/or adenoids removed? Age: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
8.	Has the patient ever had a serious illness or been hospitalized? Explain: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
9.	Does the patient have any special problems not listed? Explain: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
10.	Has the patient ever been advised by their physician to take an antibiotic prior to any dental treatments? If yes, antibiotic name and method: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
11.	Does the patient use tobacco? (smoking or chewing)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
12.	What is the patient's approximate height?	Weight? _____		
13.	Has the patient shown signs of increased growth recently?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
14.	Has the patient reached puberty? Girls – started menstruating? Boys – voice changed?	<input type="checkbox"/> YES <input type="checkbox"/> YES <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> NO <input type="checkbox"/> NO	
15.	Father's present height: _____ Older brother's present height: _____	Mother's present height: _____ Older sister's present height: _____		

DOES THE PATIENT NOW, OR HAVE THEY EVER HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY LUNG DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	ADD
<input type="checkbox"/>	<input type="checkbox"/>	ENDOCARDITIS	<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY TROUBLE
<input type="checkbox"/>	<input type="checkbox"/>	HEART CONDITION	<input type="checkbox"/>	<input type="checkbox"/>	LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	LIVER DISEASE
<input type="checkbox"/>	<input type="checkbox"/>	HEART PACEMAKER	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS (type? _____)	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC TREATMENT
<input type="checkbox"/>	<input type="checkbox"/>	HEART ANGINA	<input type="checkbox"/>	<input type="checkbox"/>	VENEREAL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	DRUG ADDICTION
<input type="checkbox"/>	<input type="checkbox"/>	HEART ATTACK (CORONARY)	<input type="checkbox"/>	<input type="checkbox"/>	HERPES (ORAL-COLD SORES)	<input type="checkbox"/>	<input type="checkbox"/>	HEADACHES
<input type="checkbox"/>	<input type="checkbox"/>	MITRAL VALVE PROLAPSE	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD DISORDERS/BLEEDING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	EARACHES
<input type="checkbox"/>	<input type="checkbox"/>	CONGENITAL HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	INFLAMMATORY RHEUMATISM	<input type="checkbox"/>	<input type="checkbox"/>	JAW CLICKING
<input type="checkbox"/>	<input type="checkbox"/>	ARTIFICIAL HEART VALVE	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES
<input type="checkbox"/>	<input type="checkbox"/>	HEART SURGERY; date _____	<input type="checkbox"/>	<input type="checkbox"/>	ULCERS	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES TO METAL
<input type="checkbox"/>	<input type="checkbox"/>	HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	STROKE	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES TO LATEX
<input type="checkbox"/>	<input type="checkbox"/>	RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>	JAW PAIN
<input type="checkbox"/>	<input type="checkbox"/>	PROSTHETIC (ARTIFICIAL) JOINT	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	TONSILLITIS
<input type="checkbox"/>	<input type="checkbox"/>	X-RAY/RADIATION (CANCER) THERAPY	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>	EMOTIONAL PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	AIDS OR H.I.V. POSITIVE	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____
<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	FAINTING SPELLS			

MEMO:

I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct. THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE INFORMATION NOT DISCLOSED. I grant authority to the Doctor and Staff to perform all procedures and treatments in the patient's best interest. I understand that, where appropriate, Credit Bureau reports may be obtained. I authorize the Orthodontist to share this patient's treatment information with collaborating dentists and surgeons when appropriate. I authorize the Orthodontist to submit treatment information pertinent to this patient to the insurance company for billing purposes only.

Signature of parent or guardian _____ Signature of Orthodontist _____	Today's Date _____ Update _____ Initial _____ Update _____ Initial _____ Update _____ Initial _____ Update _____ Initial _____
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NOTES:
