



# Medical Dental History Form for Adult Patients

## PATIENT

Date \_\_\_\_\_

Patient's last name \_\_\_\_\_ First name \_\_\_\_\_ Middle initial \_\_\_\_\_

Title Mr. Mrs. Ms. 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. Ms. 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 dentists/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 page 1) \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home phone ( ) \_\_\_\_\_ - \_\_\_\_\_ 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

- Birth defects or hereditary problems?
- Bone fractures or major injuries?
- Any injuries to face, head, neck?
- Arthritis or joint problems?
- Endocrine or thyroid problems?
- Diabetes or low sugar?
- Kidney problems?
- Cancer, tumor, radiation treatment or chemotherapy?
- Stomach ulcer, hyperacidity, acid reflux?
- Immune system problems?
- History of osteoporosis?
- Gonorrhea, syphilis, herpes, sexually transmitted diseases?
- AIDS or HIV positive?
- Hepatitis, jaundice, or other liver problems?
- Polio, mononucleosis, tuberculosis, pneumonia?
- Seizures, fainting spells, neurologic problems?
- Mental health disturbance or depression?
- Vision, hearing, or speech problems?
- History of eating disorder (anorexia, bulimia)?
- High or low blood pressure?
- Excessive bleeding or bruising, anemia?
- Chest pain, shortness of breath, tire easily, swollen ankles?
- Heart defects, heart murmur, rheumatic heart disease?
- Angina, arteriosclerosis, stroke or heart attack?
- Skin disorder (other than common acne)?
- Do you eat a well-balanced diet?
- Frequent headaches or migraines?
- Frequent ear infections, colds, throat infections?
- Asthma, sinus problems, hayfever?
- Tonsil or adenoid condition?
- Do you frequently breathe through your mouth?

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

Yes No DK/U

- Local anesthetics (novocaine, lidocaine, xylocaine)
- Latex (gloves, balloons)
- Aspirin
- Metals (jewelry, clothing snaps)
- Penicillin
- Other antibiotics
- Ibuprofen (Motrin, Advil)
- Acrylics
- Plant pollens
- Animals
- Foods
- Other substances \_\_\_\_\_

## DENTAL HISTORY

**Now or in the past, have you had:**

Yes No DK/U

- Permanent or extra (supernumerary) teeth removed?
- Supernumerary (extra) or congenitally missing teeth?
- Chipped or injured primary or permanent teeth?
- Any sensitive or sore teeth?
- Bleeding gums, bad taste or mouth odor?
- Jaw fractures, cysts, infections?
- Any teeth treated with root canals or pulpotomies?
- "Gum boils," frequent canker sores or cold sores?
- History of speech problems or speech therapy?
- Difficulty breathing through nose?
- Food impaction between the teeth?
- Mouth breathing habit or snoring at night?
- Frequent oral habits (sucking finger, chewing pen, etc)?
- Teeth causing irritation to lip, cheek or gums?
- Abnormal swallowing (tongue thrust)?
- Tooth grinding or clenching?
- Clicking, locking in jaw joints?
- Soreness in jaw muscles or face muscles?
- Ringing in ears, difficulty in chewing or opening jaw?
- Have you ever been treated for "TMJ" or "TMD" problems?
- Any broken or missing fillings?
- Any serious trouble associated with previous dental treatment?
- Have you ever been diagnosed with gum disease or pyorrhea?
- 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 take antibiotic pre-medication before any dental procedures? \_\_\_\_\_

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 \_\_\_\_\_