Medical/Dental History Form-Adult

Date: _____

Patient's Last Name: _____ First Name: _____ M.I.: ___

Birth Date: _____ Age: _____ Sex: Male ☐ Female ☐

I prefer To Be Called: _____ Home Phone: _____ Cell Phone: _____

Page Number: _____ E-mail address: _____

Patient's Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Years at above address: _____

If less than 5 years at current address, previous address: _____

_____ Years at previous address: _____

Patient is: Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

Occupation: _____ Employer: _____

Years with Employer: _____ Business Phone No.: _____

Name of Spouse/Closest Relative:

_____

Relationship to You: _____ Phone No.:_____

Address (if different than yours): _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Name of Patient's Dentist: _____Phone No.:_____

Dentist's Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Date Last Seen: _____ Reason: _____

Who suggested that you may need orthodontic treatment? _____

Why did you select this office? _____

Who is Financially Responsible for this Account?

Last Name: _____First Name: _____ M.I._____

Address (if different than Patient's): _____

Phone No.: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Insurance Coverage for Dental Treatment? Yes ☐ No ☐

Insurance Coverage for Orthodontic Treatment? Yes ☐ No ☐

Primary Policy Holder's Name: _____

S.S.N./S.I.N.:_____ Birth Date: _____

Employed By: _____

Dental Insurance Company: _____ Group No.: _____

Secondary Policy Holder's Name: _____

S.S.N. /S.I.N.: _____ Birth Date: _____

Employed By: _____

Dental Insurance Company: _____ Group No.:_____

Why did you select our office? _____

For the following questions mark yes, no, or don't know (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Patient Profile

Y N DK/U Does patient follow directions well?
Y N DK/U Does patient brush his/her teeth conscientiously?
Y N DK/U Does patient have learning disabilities or need extra help with instructions?
Y N DK/U Is patient sensitive or self-conscious about teeth?

Medical History

Now or in the past, have you had:
Y N DK/U Birth defects or hereditary problems?
Y N DK/U Bone fractures, any major accidents?
Y N DK/U Rheumatoid or arthritic conditions?
Y N DK/U Endocrine or thyroid problems?
Y N DK/U Diabetes?
Y N DK/U Cancer, tumor, radiation treatment or chemotherapy?
Y N DK/U Stomach ulcer or hyperacidity?
Y N DK/U Problems of the immune system?
Y N DK/U AIDS or HIV positive?
Y N DK/U Fainting spells, seizures, epilepsy or neurological problem?
Y N DK/U Mental health disturbance or depression?
Y N DK/U Vision, hearing, tasting or speech difficulties?
Y N DK/U History of eating disorder (anorexia, bulimia)?
Y N DK/U Excessive bleeding or bruising tendency, anemia or bleeding disorder?
Y N DK/U High or low blood pressure?
Y N DK/U Cardiovascular problem: (heart trouble, heart attack, angina, coronary insufficiency, arterioscerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
Y N DK/U Do you have a well-balanced diet?
Y N DK/U Frequent headaches, colds or sore throats?
Y N DK/U Eye, ear, nose or throat condition?
Y N DK/U Hayfever, asthma, sinus trouble or hives?
Y N DK/U Tonsil or adenoid conditions?
Y N DK/U Osteoporosis?

Allergies or reactions to any of the following:

Y N DK/U Local anesthetics (Novacaine or Lidocaine)
Y N DK/U Aspirin
Y N DK/U Ibuprofen (Motrin/Advil)
Y N DK/U Penicillin or other antibiotics
Y N DK/U Sulfa drugs
Y N DK/U Metals (jewelry, clothing snaps)
Y N DK/U Latex (gloves, balloons)
Y N DK/U Acrylic
Y N DK/U Foods (specify) _____
Y N DK/U Other substances (specify) _____
Y N DK/U Are you taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them:
Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
Y N DK/U Any medications for Osteoporosis (such as Fosamax)?

Y N DK/U Do you currently have or ever had a substance abuse problem?
Y N DK/U Do you chew or smoke tobacco?
Y N DK/U Hospitalized or Operations? Describe: _____
Do you have any other medical conditions that we should know about? _____
Are there family medical conditions that we should know about? _____
_____

Women Only

Y N DK/U Are you pregnant?
Y N DK/U Are you anticipating becoming pregnant?

Dental History

Now or in the past, have you had:

☐ Y ☐ N ☐ DK/U Permanent or "extra" (supernumerary) teeth removed?
☐ Y ☐ N ☐ DK/U Supernumerary (extra) or congenitally missing teeth?
☐ Y ☐ N ☐ DK/U Chipped or otherwise injured primary (baby) or permanent teeth?
☐ Y ☐ N ☐ DK/U Teeth sensitive to hot or cold; teeth throb or ache?
☐ Y ☐ N ☐ DK/U Jaw fractures, cysts or mouth infections?
☐ Y ☐ N ☐ DK/U "Dead teeth" or root canals treated?
☐ Y ☐ N ☐ DK/U Bleeding gums, bad taste or mouth odor?
☐ Y ☐ N ☐ DK/U Periodontal "gum problems"?
☐ Y ☐ N ☐ DK/U Food sticking or getting caught between teeth?
☐ Y ☐ N ☐ DK/U "Gum boils" frequent canker sores or cold sores?
☐ Y ☐ N ☐ DK/U Thumb, finger, or sucking habit? Until what age?_____
☐ Y ☐ N ☐ DK/U Abnormal swallowing habit (tongue thrusting)?
☐ Y ☐ N ☐ DK/U History of speech problems?
☐ Y ☐ N ☐ DK/U Mouth breathing habit, snoring or difficulty in breathing?
☐ Y ☐ N ☐ DK/U Tooth grinding or jaw clenching?
☐ Y ☐ N ☐ DK/U Any pain, clicking or locking in jaw or ringing in the ears?
☐ Y ☐ N ☐ DK/U Any pain or soreness in the muscles of the face or around the ears?
☐ Y ☐ N ☐ DK/U Difficulty in chewing or jaw opening?
☐ Y ☐ N ☐ DK/U Have you ever been treated for "TMD" or "TMJ" problems?
☐ Y ☐ N ☐ DK/U Concerned about spaced, crooked or protruding teeth?
☐ Y ☐ N ☐ DK/U Any relative with similar tooth or jaw relationships?
☐ Y ☐ N ☐ DK/U Had periodontal (gum) treatment?
☐ Y ☐ N ☐ DK/U Had any serious trouble associated with any previous dental treatment?
☐ Y ☐ N ☐ DK/U Been under another dentist's care?
Specialist _____
Other _____
☐ Y ☐ N ☐ DK/U Ever had a prior orthodontic examination or treatment?
☐ Y ☐ N ☐ DK/U Would you object to wearing orthodontic appliances (braces) should they be indicated?

How often do you brush: _____ Floss: _____

What is your primary concern? Why are you here? _____

_____
_____

I have read and understand the above questions. 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. If there are any changes later to this history record or medical/dental status. I will so inform this practice.

Signed: _____ Date Signed: _____
(Patient)
Signed: _____Date Signed: _____
(Dental staff member)