CONFIDENTIAL

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 _______________ Age _____ Sex Male Female Transgender Other ________________
Social Security #_________-_________-_________
Marital Status Single Married Separated Divorced Widowed
Home address ______________________________________ City, State, Zip code: _________________________
Home phone (_________) _________-_________ Cell phone (_________) _________-_________
Work phone (_________) _________-_________
E-mail address(es) ____
Occupation ____ Employer ___________________________________

CLOSEST RELATIVE

Spouse or closest relative's name(s) ____
Title Mr. Mrs. Ms. Miss Dr. Other _________ Relationship to patient ________________
Address (*if different than patient address*) ____
Cell phone (_________) _________-_________ Home 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 ____

PHYSICAN

Patient's Physician ____________________________ Address, 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. ___________
Whom may we thank for referring you to this office? ____
Would you change anything about your teeth or smile? ____
What do you expect from treatment? ____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? ____

Address (*if different from page 1*) _____________________________ City, State, Zip ____________________

Cell phone (_________) _________-_________ Home phone (_________) _________-_________

Email address ____

Social Security #_________-_________-_________ Employer ______________________________________

Who will be responsible for bringing the patient to orthodontic appointments? ________________________

I understand that if I choose extended payments for services that a credit report may be necessary.

Sign here: ____ Date: _____________

ORTHODONTIC 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, mark yes, no, or don't know/understand (dk/u).

MEDICAL HISTORY

Now or in the past, have you had:

- yes no dk/u Have you ever taken intravenous medication for bone disorders or cancer such as bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate), or Didronel (etidronate)?
- yes no dk/u Have you ever taken oral medication for bone disorders such as bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate), or Didronel (etidronate)?
- yes no dk/u Birth defects or hereditary problems?
- yes no dk/u Bone fractures, or major injuries?
- yes no dk/u Any injuries to the face, head, neck?
- yes no dk/u Arthritis or joint problems?
- yes no dk/u Cancer, tumor, radiation treatment or chemotherapy?
- yes no dk/u Endocrine or thyroid problems?
- yes no dk/u Diabetes or low sugar?
- yes no dk/u Kidney problems?

yes no dk/u Stomach ulcer, hyperacidity, acid reflux?
yes no dk/u Immune system problems?
yes no dk/u History of osteoporosis?
yes no dk/u Gonorrhea, syphilis, herpes, sexually transmitted diseases?
yes no dk/u AIDS or HIV positive?
yes no dk/u Hepatitis, jaundice, or other liver problems?
yes no dk/u Polio, mononucleosis, tuberculosis, pneumonia?
yes no dk/u Seizures, fainting spells, neurologic problems?
yes no dk/u Mental health disturbance or depression?
yes no dk/u History of eating disorder (anorexia, bulimia)?
yes no dk/u Frequent headaches or migraines?
yes no dk/u High or low blood pressure?
yes no dk/u Excessive bleeding or bruising tendency, anemia?
yes no dk/u Chest pain, shortness of breath, tire easily, swollen ankles?
yes no dk/u Heart defects, heart murmur, rheumatic heart disease?
yes no dk/u Angina, arteriosclerosis, stroke, or heart attack?
yes no dk/u Skin disorder (other than common acne)?
yes no dk/u Does you eat a well-balanced diet?
yes no dk/u Vision, hearing, or speech problems?
yes no dk/u Frequent ear infections, colds, throat infections?
yes no dk/u Asthma, sinus problems, hay fever?
yes no dk/u Tonsil or adenoid condition?
yes no dk/u Do you frequently breathe through your mouth?
yes no dk/u Surgery of the head or face?
yes no dk/u Blood disorders?
yes no dk/u Frequent neck or backaches?
yes no dk/u A low pain tolerance?
yes no dk/u Any other health problems? ____

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

yes no dk/u Latex (gloves, balloons)
yes no dk/u Metals (jewelry, clothing snaps)
yes no dk/u Acrylics
yes no dk/u Local anesthetics (novocaine, lidocaine, xylocaine)
yes no dk/u Aspirin
yes no dk/u Ibuprofen (Motrin, Advil)
yes no dk/u Penicillin
yes no dk/u Other antibiotics ____
yes no dk/u Plant pollens
yes no dk/u Animals
yes no dk/u Foods
yes no dk/u Other substances ____

DENTAL HISTORY

Now or in the past, have you had:

yes no dk/u Permanent or extra (supernumerary) teeth removed?
yes no dk/u Supernumerary (extra) or congenitally missing teeth?
yes no dk/u Chipped or injured primary or permanent teeth?
yes no dk/u Bleeding gums, bad taste, or mouth odor?

yes no dk/u Jaw fractures, cysts, infections?
yes no dk/u Any teeth treated with root canals or pulpotomies?
yes no dk/u "Gum boils," frequent canker sores or cold sores?
yes no dk/u History of speech problems or speech therapy?
yes no dk/u Difficulty breathing through nose?
yes no dk/u Food impaction between the teeth?
yes no dk/u Mouth breathing habit or snoring at night?
yes no dk/u History of speech problems?
yes no dk/u Frequent oral habits (sucking finger, chewing pen, biting nails, etc.)
yes no dk/u Teeth causing irritation to lip, cheek, or gums?
yes no dk/u Abnormal swallowing (tongue thrust)?
yes no dk/u Tooth grinding or clenching?
yes no dk/u Clicking, locking in jaw joints?
yes no dk/u Soreness in jaw muscles or face muscles?
yes no dk/u Ringing in ears, difficulty chewing or opening jaw?
yes no dk/u Have you ever been treated for "TMJ" or "TMD" problems?
yes no dk/u Any broken or missing fillings?
yes no dk/u Have you ever been diagnosed with gum disease or pyorrhea?
yes no dk/u Have you ever had an orthodontic consultation or treatment before now?
yes no dk/u Do you have any missing back teeth with no replacements?
yes no dk/u Do you wear a removable partial or full denture?
yes no dk/u Do you have any dental crowns or bridges?
yes no dk/u Have you ever had a jaw splint or mouth guard?
yes no dk/u Have you ever had an equilibration by your family dentist to adjust your bite?
yes no dk/u Do you have difficulty opening or closing your mouth?
yes no dk/u Are you frightened or anxious about orthodontic treatment?
yes no dk/u Have you ever had an unpleasant experience in a dental office?
yes no dk/u Do you have any special concerns about orthodontic or TMJ treatment?

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 ____
Do you take antibiotic pre-medication before any dental procedures? Yes No
Do you or have you ever had a substance abuse problem? ____
Have you ever taken any medications to strengthen your bones? Please describe. _________________________
Have you chewed tobacco? Yes No Or smoked any substance or vaped? Yes No
If yes, what is the frequency? ____
Have you noticed any changes in your face or jaws? ____
Have you been hospitalized in the last 10 years? Yes No
Do you have an unusual amount of stress in your life? Yes No
Have you ever had a serious medical problem or operation? Yes No
Are you under the care of a doctor? Yes No
Do you consider yourself healthy? Yes No
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 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

Changes ____

Patient Signature ____ Date ______________

Dental Staff Signature ____ Date ______________

Changes ____

Patient Signature ____ Date ______________

Dental Staff Signature ____ Date ______________

Changes ____

Patient Signature ____ Date ______________

Dental Staff Signature ____ Date ______________