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 Do 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 _____