

 **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       Sex: Male [ ]  Female [ ]  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 relatives name(s)

Title [ ]  Mr. [ ]  Mrs. [ ]  Ms. [ ]  Miss. [ ]  Dr. [ ]  Other       Relationship to patient

Address *(if different than patient address)*

Home phone (     )      -      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 from page 1*)       City, State, Zip

Home phone (     )      -      Cell phone (     )      -      E-mail address(es)

Social Security #     -    -      Employer:

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

**DENTAL INSURANCE**

Primary policy holder’s full name       Birthdate

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       Birthdate

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 medial 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** Birth defects or hereditary problems?

**[ ] yes [ ] no [ ] dk/u** Bone fractures, or major injuries?

**[ ] yes [ ] no [ ] dk/u** Any injuries to face, head, neck?

**[ ] yes [ ] no [ ] dk/u** Arthritis or joint problems?

**[ ] 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** Cancer, tumor, radiation treatment or chemotherapy?

**[ ] 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 problem?

**[ ] yes [ ] no [ ] dk/u** Polio, mononucleosis, tuberculosis, pneumonia?

**[ ] yes [ ] no [ ] dk/u** Seizures, fainting spells, neurologic problem?

**[ ] yes [ ] no [ ] dk/u** Mental health disturbance or depression?

**[ ] yes [ ] no [ ] dk/u** Vision, hearing, or speech problems?

**[ ] yes [ ] no [ ] dk/u** History of eating disorder (anorexia, bulimia)?

**[ ] yes [ ] no [ ] dk/u** High or low blood pressure?

**[ ] yes [ ] no [ ] dk/u** Excessive bleeding or bruising, 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** Frequent headaches or migraines?

**[ ] yes [ ] no [ ] dk/u** Frequent ear infections, colds, throat infections?

**[ ] yes [ ] no [ ] dk/u** Asthma, sinus problems, hayfever?

**[ ] yes [ ] no [ ] dk/u** Tonsil r adenoid condition?

**[ ] yes [ ] no [ ] dk/u** 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)

**[ ] yes [ ] no [ ] dk/u** Latex (gloves, balloons)

**[ ] 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** Metals (jewelry, clothing snaps)

**[ ] yes [ ] no [ ] dk/u** Acrylics

**[ ] 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** Any sensitive or sore 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,” **f**requent 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, 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 in 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** Any serious trouble associate with previous dental

 treatment?

**[ ] 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?

**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 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

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Staff Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Changes

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Staff Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Changes

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Staff Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_