

**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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_