

CONFIDENTIAL

Medical Dental History Form for Adult Patients

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Date
Patient's Last name First name Middle initial
Title Mr. Mrs. Mss. Miss. Dr. Other I prefer to be called
Birth date Sex: Male _ Female _ Social Security #
Marital Status
Home address City, State, Zip code
Cell phone () Home phone ()
Work phone ()
E-mail address(es)
Occupation Employer
CLOSEST RELATIVE
Spouse or closest relative's name(s)
Title Mr. Mrs. Mss. 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
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

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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 ____ Cell phone (______) _____ Home 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 # ____ **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).

MEDIC	AL HISTO	DRY	□ yes □ yes		☐ dk/u ☐ dk/u	
Now or in the past, have you had:		☐ yes	no no	☐ dk/u	Other substances	
□ yes □	no dk,	Yu Have you ever taken intravenous medication for bone disorders or cancer such as bisphosphonates 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 Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel	DEN	Γ AL Η	ISTOR'	Υ
		(etidronate)?	Now o	r in th	e past, I	nave you had:
ges [no dk/	'u Birth defects or hereditary problems? 'u Bone fractures, or major injuries? 'u Any injuries to face, head, neck?	☐ yes ☐ yes ☐ yes	no	☐ dk/u	Permanent or extra (supernumerary) teeth removed? Supernumerary (extra) or congenitally missing teeth? Chipped or injured primary or permanent teeth?
ges [no dk	/u Arthritis or joint problems?	☐ yes	☐ no	☐ dk/u	Any sensitive or sore teeth?
	:	'u Endocrine or thyroid problems?	yes			Bleeding gums, bad taste or mouth odor?
	:	/u Diabetes or low sugar?	yes			Jaw fractures, cysts, infections?
		/u Kidney problems?	☐ yes	_		Any teeth treated with root canals or pulpotomies? "Gum boils," frequent capter series or cold series?
	:	/u Cancer, tumor, radiation treatment or chemotherapy?	☐ yes			"Gum boils," frequent canker sores or cold sores?
	^	/u Stomach ulcer, hyperacidity, acid reflux?	☐ yes	_		History of speech problems or speech therapy? Difficulty breathing through nose?
	:	/u Immune system problems?	☐ yes	_		Food impaction between the teeth?
= =		/u History of osteoporosis?	☐ yes			Mouth breathing habit or snoring at night?
∐ yes		'u Gonorrhea, syphilis, herpes, sexually transmitted diseases?	☐ yes			History of speech problems?
□ yes □	□ no □ dk/	'u AIDS or HIV positive?	☐ yes			Frequent oral habits (sucking finger, chewing pen,
☐ yes ☐	no dk/	'u Hepatitis, jaundice or other liver problem?	_	_	_	etc.)?
☐ yes ☐	□ no □ dk/	'u Polio, mononucleosis, tuberculosis, pneumonia?	☐ yes	no no	☐ dk/u	Teeth causing irritation to lip, cheek or gums?
☐ yes ☐	☐ no ☐ dk/	'u Seizures, fainting spells, neurologic problem?	☐ yes	no no	☐ dk/u	Abnormal swallowing (tongue thrust)?
☐ yes ☐	□ no □ dk/	'u Mental health disturbance or depression?	☐ yes	no no	☐ dk/u	Tooth grinding or clenching?
☐ yes ☐	□ no □ dk/	'u Vision, hearing, or speech problems?	☐ yes	no no	☐ dk/u	Clicking, locking in jaw joints?
☐ yes ☐	□ no □ dk/	'u History of eating disorder (anorexia, bulimia)?	☐ yes			Soreness in jaw muscles or face muscles?
☐ yes ☐	☐ no ☐ dk/	'u High or low blood pressure?	☐ yes			Ringing in ears, difficulty in chewing or opening jaw?
	:	'u Excessive bleeding or bruising, anemia?	☐ yes	∐ no	∐ dk/u	Have you ever been treated for "TMJ" or "TMD" problems?
yes	no dk _/	'u Chest pain, shortness of breath, tire easily, swollen ankles?	☐ yes	□no	□ dk/u	Any broken or missing fillings?
		/u Heart defects, heart murmur, rheumatic heart disease?	□ yes	_		Any serious trouble associate with previous dental treatment?
		'u Angina, arteriosclerosis, stroke or heart attack?	☐ yes	no no	☐ dk/u	Have you ever been diagnosed with gum disease or pyorrhea?
		/u Skin disorder (other than common acne)?	□ yes	□no	□ dk/u	Have you ever had an orthodontic consultation or
	:	/u Do you eat a well-balanced diet?				treatment before now
	:	/u Frequent headaches or migraines?				
	`	/u Frequent ear infections, colds, throat infections?				
	^	/u Asthma, sinus problems, hayfever?				
		/u Tonsil or adenoid condition? /u Do you frequently breathe through your mouth?				
		a bo you nequently breathe through your mount:				
Have you	u had allei	gies 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				
	:	'u Other antibiotics				
☐ yes ☐	□ no □ dk/	'u Plant pollens				

PATIENT HEALTH INFORMATION

List any medication, nutritional supplements, herbal medications or non-prescription managements that you take.	nedicines, including fluoride
Do you take antibiotic pre-medication before any dental procedures? Yes No	
Medication Taken for Medication Taken for	
Medication Taken for Medication Taken for	
Have you ever taken any medications to strengthen your bones? Please describe.	<u></u>
Do you or have you ever had a substance abuse problem?	
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?	
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 pregna	nt?
FAMILY MEDICAL HISTORY	
Have your parents or siblings ever had any of the following health problems? If so, please	ase 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 me any errors or omissions that I have made in the completion of this form. I will notify my orthodo dental health.	
Signature	Date
MEDICAL HISTORY UPDATES OR CHANGES	
Changes	
Patient Signature Dental Staff Signature	Date Date
	24.0
Changes	Date
Patient Signature Dental Staff Signature	Date Date
Changes	Dete
Patient Signature Dental Staff Signature	Date Date