Date ______________

CONFIDENTIAL

MEDICAL DENTAL HISTORY FORM FOR ADULT PATIENTS

PATIENT

Last name ______________________________ First name __________________________ Middle initial ______

Birth date ______________________________ Name I prefer to be called ______________________________

What sex were you assigned at birth? Male ☐ Female ☐ SS# ____

Home address ____

City/State/Zip ____

Cell phone number _______________________________ Email address _________________________________

Marital Status Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Occupation ____ Employer ____________________________________

CLOSEST RELATIVE

Name of spouse/closest relative ______________________________ Relationship to you ________________

Phone number (if different from yours) ____

Address (if different from yours)____

City/State/Zip (if different than yours) ____

DENTIST

Dentist ____ Phone number _____________________________

Dentist’s address ____

City/State/Zip____

Date last seen _________________ Reason ____

PHYSICIAN

Physician ____ Phone number ____________________________

Physician’s address ____

City/State/Zip ____

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 ______________________________

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account?

Last name ______________________________ First name ________________________ Middle initial _____

Address (if different from yours)____

City/State/Zip (if different than yours) ____

Email address ____ Cell phone ___________________________

Employer ____ SS#_______________________________

DENTAL INSURANCE

Primary policy holder's name ________________________________ Date of birth ______________________

SS# ______________________ Employer ____

Insurance company _______________________________________ Group number _____________________

Does this policy have orthodontic benefits? Yes □ No □ Don't know □

Secondary policy holder's name ______________________________ Date of birth ______________________

SS# ________________________ Employer ____

Insurance company _______________________________________ Group number _____________________

Does this policy have orthodontic benefits? Yes □ No □ Don't know □

For the following questions, mark yes, no, or don't know/understand (dk/u). Your answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

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," 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, 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 or 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 Been treated for "TMJ" or "TMD" problems?
□yes □no □dk/u Any broken or missing fillings?
□yes □no □dk/u Any serious trouble associated with previous dental treatment?
□yes □no □dk/u Been diagnosed with gum disease or pyorrhea?
□yes □no □dk/u Have you ever had an orthodontic consultation or treatment before now?

MEDICAL HISTORY

Now or in the past, have you had:

- □yes □no □dk/u Have you ever taken IV medication for bone disorders or cancer such as bisphosphonates 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 (etidronate)?
- □yes □no □dk/u Heredity or developmental conditions?
- □yes □no □dk/u Bone fractures or any major injuries?
- □yes □no □dk/u Any injuries to face, head, or 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, or any 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, or pneumonia?
- □yes □no □dk/u Seizures, fainting spells, or neurological problems?
- □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, or anemia?
- □yes □no □dk/u Chest pain, shortness of breath, tire easily, or swollen ankles?
- □yes □no □dk/u Heart defects, heart murmur, or rheumatic heart disease?
- □yes □no □dk/u Angina, arteriosclerosis, stroke, or heart attack?
- □yes □no □dk/u Skin disorder (other than 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, or throat infections?
- □yes □no □dk/u Asthma, sinus problems, or hay fever?
- □yes □no □dk/u Tonsil or adenoid condition?
- □yes □no □dk/u Do you frequently breathe through your mouth?

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 substance ___________________

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 ____

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 ___________ Medication ________________ Taken for ___________

Do you take antibiotic pre-medication before any dental procedures? □ Yes □ No

Have you ever taken any medication to strengthen your bones? Please describe ___________________________

Do you or have you ever had a substance abuse problem? Please explain ________________________________

Have you chewed tobacco? Yes □ No □ Have you 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 ONLY: Are you pregnant? Yes □ No □ Are you trying to become pregnant? Yes □ No □

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 UPDATE OR CHANGES

Changes ____

Patient signature ____ Date signed: ____________________

Dental staff signature ____ Date signed: ____________________

Changes ____

Patient signature ____ Date signed: ____________________

Dental staff signature ____ Date signed: ____________________

Changes ____

Patient signature ____ Date signed: ____________________

Dental staff signature ____ Date signed: ____________________