

Medical/Dental History - Adult

Date: ___/___/___ Who may we thank for referring you?: _____

Patient's Name: _____ Sex: M / F Age: _____ Birthdate: ___/___/___

Prefers to be addressed as: _____ Phone #: _____ Cell #: _____

Address: _____ City: _____ State: _____ Zip: _____ Email Address: _____

Employed by: _____ Occupation: _____ Work Phone: _____

Marital Status: Married Single Divorced Separated Widowed

Spouse's Name: _____ Occupation: _____ Work Phone: _____

Employed by: _____ If Children, Name: _____ Name: _____
DOB: ___/___/___ DOB: ___/___/___

Person Responsible for Account: _____ SS #: _____ Phone #: _____
 Self Spouse Other:

Address: _____ Business Phone: _____ Cell #: _____

Contact in case of Emergency: Name: _____ Phone #: _____ Cell #: _____

DENTAL INSURANCE

Primary Insurance Co: _____ Gr. #: _____ Ortho Coverage: Yes No

Insured's Name: _____ SS #: _____ Birthdate: ___/___/___

Secondary Insurance Co: _____ Gr. #: _____ Ortho Coverage: Yes No

Insured's Name: _____ SS #: _____ Birthdate: ___/___/___

Other Insurance Information: _____

DENTAL HISTORY

Patient Dentist Name: _____ Date of Last Visit: _____

1. Have there been any injuries to the face, mouth or teeth? YES NO

2. Have you had or do you presently have any of the following habits? Thumb or finger sucking Lip Biting Snoring
 Grinding of teeth at night Mouth breathing

3. Have you been informed of any missing or extra permanent teeth? YES NO

4. Are you aware of sores, lumps or irritated areas in the mouth? YES NO

5. Has an orthodontist been consulted previously? YES NO
Name: _____ Date: _____

6. Have you ever been treated for: Bad Bite TMJ Periodontal disease None
If so, by whom?: _____

7. Do you have any speech problems? YES NO

8. Are you frightened or anxious about Orthodontic treatment? YES NO

9. Are you concerned about the appearance of your teeth? YES NO

10. Is there anything you would like to change about your smile? YES NO
If so, what: _____

11. What aspect of dental treatment are you most concerned with? Quality Cost Discomfort Time

12. Reason for consultation (chief concern): _____

13. Has there ever been any orthodontic treatment for any other member of your family? YES NO
Were they satisfied with the results? YES NO Stage of TX: _____

Children (Dr. _____) Spouse (Dr. _____) Other Family Members (Dr. _____)

MEDICAL HISTORY

COMMENTS:

1. Is your general health good at this time? YES NO
2. Are you under the care of a physician at this time? YES NO
Explain: _____
3. What is the name of your family physician? _____ Date of last physical: _____
4. Are you taking any medication? YES NO
Name: _____
5. Are you allergic to any medication? (Penicillin, Sulfa, etc.) YES NO
Name: _____
6. Have you ever taken any diet medication (Fen-Phen)? YES NO
7. Have you ever had a serious illness or been hospitalized? YES NO
Explain: _____
8. Have you had your tonsils and/or adenoids removed? YES NO
Age: _____
9. Do you have any special problems not listed? YES NO
Explain: _____
10. Have you ever been advised by your physician to take an antibiotic prior to any dental treatments? YES NO
If yes, antibiotic name and method: _____ Pharmacy: _____
11. Do you use tobacco? (smoking or chewing) YES NO
12. What is your approximate height? _____ Weight? _____
13. WOMEN:
Are you pregnant or considering pregnancy during the next 2 years? YES NO Are you nursing? YES NO
Are you currently taking medication for birth control? YES NO

DO YOU HAVE NOW, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

- | YES | NO | YES | NO | YES | NO | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | TUBERCULOSIS |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | DIABETES |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ENDOCARDITIS |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | RESPIRATORY LUNG DISEASE |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HEART CONDITION |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HIGH BLOOD PRESSURE |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HEART PACEMAKER |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | LOW BLOOD PRESSURE |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HEART ANGINA |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HEPATITIS (type? _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HEART ATTACK (CORONARY) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | VENEREAL DISEASE |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | MITRAL VALVE PROLAPSE |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HERPES (ORAL-COLD SORES) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | BLOOD DISORDERS/BLEEDING PROBLEMS |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | CONGENITAL HEART DISEASE |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | INFLAMMATORY RHEUMATISM |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ARTIFICIAL HEART VALVE |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HEART SURGERY; date _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ULCERS |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | STROKE |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ANEMIA |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | RHEUMATIC FEVER |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ASTHMA |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ARTHRITIS / OSTEOPOROSIS / BISPHOSPHONATES |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | EPILEPSY |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | GLAUCOMA |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | FAINTING SPELLS |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ADD |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | KIDNEY TROUBLE |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | LIVER DISEASE |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | PSYCHIATRIC TREATMENT |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | DRUG ADDICTION |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HEADACHES |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | EARACHES |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | JAW CLICKING |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ALLERGIES |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ALLERGIES TO METAL |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ALLERGIES TO LATEX |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | JAW PAIN |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | TONSILLITIS |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | EMOTIONAL PROBLEMS |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | OTHER: _____ |

MEMO:

I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct. **THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE INFORMATION.** I grant authority to the Doctor and Staff to perform all procedures and treatments in my best interest. I authorize the Orthodontist to share treatment information with collaborating dentists and surgeons when appropriate. I authorize the Orthodontist to submit treatment information pertinent to this patient to the Insurance Company for billing purposes only. I understand that, when appropriate, Credit Bureau reports may be obtained.

Signature of Patient _____

Signature of Orthodontist _____

Today's Date _____

Update _____ Initial _____

Update _____ Initial _____

Update _____ Initial _____

Update _____ Initial _____

NOTES:
