

*Welcome!*

Medical / Dental History Form  
For Adults

Date: \_\_\_\_\_

Patient's Full Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Social Security Number \_\_\_\_\_

Address (street) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Employed By \_\_\_\_\_

Occupation \_\_\_\_\_ Business Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Employed By \_\_\_\_\_ Business Phone \_\_\_\_\_

Marital Status: Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed \_\_\_\_\_ Single \_\_\_\_\_

Current Dentist \_\_\_\_\_ Phone Number \_\_\_\_\_

Current Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Do you have Orthodontic Insurance? Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes, please complete the information below

Insurance Provider \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Member Name \_\_\_\_\_ Group Number \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Member Name \_\_\_\_\_ Group Number \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Patient's Hobbies or Interests \_\_\_\_\_



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

## Medical History

**Yes No Dk/u** Jaw fractures, any major accidents?

**Yes No Dk/u** Rheumatoid or arthritic conditions?

**Yes No Dk/u** Vision, hearing, tasting or speech difficulties?

**Yes No Dk/u** Endocrine or thyroid problems?

**Yes No Dk/u** Loss of weight recently, poor appetite?

**Yes No Dk/u** Excessive bleeding, black and blue tendency, anemia or bleeding disorder?

**Yes No Dk/u** High or low blood pressure?

**Yes No Dk/u** Cardiovascular problem (heart trouble) heart defects, coronary insufficiency?

**Yes No Dk/u** Problems of the immune system?

**Yes No Dk/u** AIDS or HIV positive?

**Yes No Dk/u** Tonsil or adenoid conditions?

**Yes No Dk/u** Mental health or behavioral problems?

**Yes No Dk/u** Hayfever, asthma, sinus trouble?

**Yes No Dk/u** Diabetes?

**Yes No Dk/u** Stomach ulcer or hyperacidity?

**Yes No Dk/u** Fainting spells, seizures, epilepsy or neurologic problem?

**Yes No Dk/u** Frequent headaches, colds or sore throats?

**Yes No Dk/u** Allergies or drug reactions? \_\_\_\_\_

**Yes No Dk/u** Are you taking medication, nutrient supplements or non prescription medicine? Please name them. \_\_\_\_\_

**Yes No Dk/u** Hospitalized for? \_\_\_\_\_

**Yes No Dk/u** Being treated by another health care professional for? \_\_\_\_\_

Date of last physical exam? \_\_\_\_\_

**Yes No Dk/u** Any medical concerns we should be aware of? \_\_\_\_\_

**Female Patient-** Are you currently, or anticipating becoming pregnant? \_\_\_\_\_

## Dental History

**Yes No Dk/u** Teeth sensitive to hot or cold?

**Yes No Dk/u** Frequent canker sores, or cold sores?

**Yes No Dk/u** Periodontal " Gum Problems" ?

**Yes No Dk/u** Thumb sucking, finger habit, etc?

**Yes No Dk/u** Mouth breathing habit, snoring, or difficulty in breathing?

**Yes No Dk/u** Tooth grinding, jaw clenching, clicking or locking?

**Yes No Dk/u** Any pain in jaw or ringing in the ears?

**Yes No Dk/u** Have you ever been treated for "TMJ" problems (Your jaw joint and facial muscle pain?)

**Yes No Dk/u** Do you experience any pain or soreness in the muscles of the face, or around the ears?

**Yes No Dk/u** Difficulty encountered in chewing or jaw opening?

**Yes No Dk/u** Concerned about spaced, crooked, protruding teeth?

**Yes No Dk/u** Aware or concerned about under or over developed jaw?

**Yes No Dk/u** Any relative with similar tooth or jaw relationships?

**Yes No Dk/u** Have any permanent teeth been removed?

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment? \_\_\_\_\_

**Yes No Dk/u** Has patient had any serious trouble associated with any previous dental treatment?

**Yes No Dk/u** Has patient ever had a prior orthodontic examination or treatment?

**Yes No Dk/u** Has patient recently been under another dentist's care?

Specialist? \_\_\_\_\_

**Yes No Dk/u** Date of most recent dental exam? \_\_\_\_\_

**Yes No Dk/u** What is your primary concern? – Why are you here? \_\_\_\_\_

I have read and understand the above questions. I will not hold my orthodontist or his staff responsible for any errors or omissions that I have made in completing this form. I will inform this practice of any changes.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

