

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

Cell phone \_\_\_\_\_ Home phone \_\_\_\_\_

Work phone \_\_\_\_\_

E-mail address(es) \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

**CLOSEST RELATIVE**

Spouse or closest relative's name(s) \_\_\_\_\_

Title  Mr.  Mrs.  Ms.  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 \_\_\_\_\_

## 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 # \_\_\_\_\_

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 medical 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 Have you ever taken intravenous medication for bone disorders or cancer such as bisphosphonates as Zometa (zoledronic 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 (risedronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate)?
- 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 or 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 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 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," 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, 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.

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. \_\_\_\_\_

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 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 \_\_\_\_\_