

CONFIDENTIAL
 Steven L. Hechler, D.D.S., M.S., P.A.
 12800 Metcalf Ave., #1
 Overland Park, KS 66213
 MEDICAL DENTAL HISTORY FORM
 FOR ADULT PATIENTS

Date _____

Patient's Last Name _____ First _____ Middle _____

Birth date _____ Age _____ Sex _____ Height _____ Weight _____

Patient's Address - Street _____ Home Phone # (____) _____

City _____ State _____ Zip _____

E-mail address _____ Cell Phone # (____) _____

Social Security # _____ Patient is: Single _____ Married _____ Widowed _____ Separated _____ Divorced _____

Hobbies _____ Occupation _____

Workplace _____ Position _____

Business Address _____

Business Phone # (____) _____ How long employed at this workplace? _____

Spouse Name _____ Spouse Social Security # _____

Workplace _____ Position _____

Business Address _____

Business Phone # (____) _____ How long employed at this workplace? _____

Spouse Cell Phone # (____) _____

What is the patient's primary concern? Reason you are here? _____

Other Family Members Treated _____

Who may we thank for referring you to the office? 1) _____ 2) _____

Dentist _____ Physician _____

In case we cannot reach you: Person to contact _____ Relationship to patient _____ Phone # (____) _____

Dental Insurance No _____ Yes _____ Name & Phone # of Insurance Co. _____

Name of Policy Holder _____ DOB Policy Holder _____ SS# _____

If you have orthodontics insurance, please provide the front desk your dental insurance card to copy.

Secondary Dental Insurance No _____ Yes _____ Name & Phone # of Insurance Co. _____

Name of Policy Holder _____ DOB Policy Holder _____ SS# _____

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 | Hepatitis, jaundice, or liver problems? | yes | no | dk/u | Are you taking medication, nutrient supplements or non-prescription medicine? Please name them. _____ |
| yes | no | dk/u | Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects or rheumatic heart?) | yes | no | dk/u | Thumb or finger sucking habit? Until age _____ |
| yes | no | dk/u | Heart murmur? (currently?) | yes | no | dk/u | Abnormal swallowing habit (tongue thrusting)? |
| yes | no | dk/u | Diabetes? | yes | no | dk/u | History of speech problems? |
| yes | no | dk/u | Excessive bleeding, black and blue tendency, anemia, or bleeding disorder? | yes | no | dk/u | Tooth grinding, jaw clenching? |
| yes | no | dk/u | Allergies or drug reactions? _____ | yes | no | dk/u | Mouth breathing habit, snoring, difficulty in breathing? (Circle) |
| | | | | yes | no | dk/u | History of trauma to face or teeth? |
| | | | | yes | no | dk/u | Any pain in jaw, clicking or locking? (Circle) |

