CONFIDENTIAL

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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_____How long at this address?_____Own ◯ Rent ◯
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(non-family member)_____Relationship to patient ____Phone # (____)_____
Dental Insurance No◯ Yes◯ Name & Phone # of Insurance Co. _____
Name of Policy Holder _____DOB Policy Holder_____SS#_____
If you have orthodonitcs 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 **Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects or rheumatic heart?)**

yes no dk/u **Heart murmur? (currently?)**

yes no dk/u **Diabetes?**

yes no dk/u **Excessive bleeding, black and blue tendency, anemia, or bleeding disorder?**

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 **Thumb or finger sucking habit? Until age**_____

yes no dk/u **Abnormal swallowing habit (tongue thrusting)?**

yes no dk/u **History of speech problems?**

yes no dk/u **Tooth grinding, jaw clenching?**

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)**

OVER ⇨

yes no dk/u Difficulty encountered in chewing or jaw opening?

yes no dk/u Does the patient experience any pain or soreness in the muscles of the face or around the ears?

yes no dk/u Birth defects or hereditary problems?

yes no dk/u Rheumatoid or arthritic conditions?

yes no dk/u Endocrine or thyroid problems?

yes no dk/u Kidney problems?

yes no dk/u Cancer or been treated for a tumor?

yes no dk/u Problems of the immune system?

yes no dk/u AIDS or HIV positive?

yes no dk/u Fainting spells, seizures, epilepsy or neurologic problem?

yes no dk/u Mental health or behavioral problem?

yes no dk/u High or low blood pressure?

yes no dk/u Frequent headaches, colds or sore throats?

yes no dk/u Eye, ear, nose, throat condition?

yes no dk/u Hayfever, asthma, sinus trouble, hives?

yes no dk/u Tonsil or adenoid condition?

yes no dk/u Does the patient currently have or ever had a substance abuse problem?

yes no dk/u Operations? (surgical procedures)?_____

_____

yes no dk/u Hospitalized for_____

yes no dk/u Being treated by another health care professional?For_____

_____

Date of most recent exam? _____

DENTAL HISTORY (Patient to complete)

Date of your most recent dental exam?_____

yes no dk/u Any teeth irritating cheek, lip, tongue, palate?

yes no dk/u Concerned about space, crooked, protruded teeth, etc?

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 Any wisdom tooth problems?

yes no dk/u Has the patient had any serious trouble associated with any previous dental treatment?

yes no dk/u Has the patient ever had a prior orthodontic examination or treatment?

yes no dk/u Has patient recently been under another dentist's care?
Specialist_____

Other_____

yes no dk/u Has patientever had periodontal (gum) treatment?

yes no dk/u Does patient have trouble following directions?

yes no dk/u Does patient have trouble brushing his/her teeth consistently?

yes no dk/u Does patient have learning disabilities or need extra help with instructions?

yes no dk/u Would patient object to wearing braces?

yes no dk/u Started teething very early or late? *(circle one)*

yes no dk/u Congenitally missing teeth?

yes no dk/u Chipped or otherwise injured primary (baby) or permanent teeth?

yes no dk/u Teeth sensitive to hot or cold; teeth throb or ache?

yes no dk/u Jaw fractures, cysts, mouth infections?

yes no dk/u "Dead teeth", root canals treated?

yes no dk/u Bleeding gums, bad taste, mouth odor?

yes no dk/u Periodontal "Gum Problems"?

yes no dk/u "Gum boils", frequent canker sores, cold sores?

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

_____

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice. I understand where appropriate a credit report may be obtained.

_____

Signature of patient Date

Below for Staff Use Only

Medical History Update/Changes: Date: Comments: Signature

_____

_____

_____

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_____

_____