

# Medical/Dental History - Adult

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Referred by: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Sex: M / F Age: \_\_\_\_\_ Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Prefers to be addressed as: \_\_\_\_\_ Email Address: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Employed by: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work #: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Separated  Widowed

Spouse's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work #: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ If Children, Name: \_\_\_\_\_ Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ DOB: \_\_\_\_\_

Person Responsible for Account:  
 Self  Spouse  Other: \_\_\_\_\_ SS#: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Bus. Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## DENTAL INSURANCE

Primary Insurance Co.: \_\_\_\_\_ Gr.#: \_\_\_\_\_ Ortho Coverage:  Yes  No

Address for Ins.: \_\_\_\_\_ ID# or SS#: \_\_\_\_\_ Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Secondary Insurance Co.: \_\_\_\_\_ Gr.#: \_\_\_\_\_ Ortho Coverage:  Yes  No

Address for Ins.: \_\_\_\_\_ ID# or SS#: \_\_\_\_\_ Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Other Insurance Information: \_\_\_\_\_

## DENTAL HISTORY

Patient's Dentist: \_\_\_\_\_ 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?  No  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  
if so, by whom?

7. Do you have any speech problems?  Yes  No

8. Are you concerned about the appearance of your teeth?  Yes  No

9. Is there anything you would like to change about your smile?  Yes  No  
If so, what:

10. Reason for consultation (Chief Concern): \_\_\_\_\_

11. Has there ever been any orthodontic treatment for any other member of the family?  Yes  No

Children (Dr. \_\_\_\_\_ ) Spouse (Dr. \_\_\_\_\_ ) Other Family Members (Dr. \_\_\_\_\_ )

# MEDICAL HISTORY

	CIRCLE ONE	COMMENTS:
1. Is your general health good at this time?	Yes    No	
2. What is the name of your physician?	Date of last physical:	
3. Are you under the care of a physician at this time? Explain:	Yes    No	
4. Are you taking any medication? Name:	Yes    No	
5. Are you taking hormone replacement, calcium replacement, bisphosphonates or osteoporosis treatment medications? Explain:	Yes    No	
6. Are you allergic to any medication? (Penicillin, Sulfa, etc.) Name:	Yes    No	
7. Have you ever taken any diet medication? (Fen-Phen)	Yes    No	
8. Have you ever had tonsils and/or adenoids removed? Age:	Yes    No	
9. Have you ever had a serious illness or been hospitalized? Explain:	Yes    No	
10. Do you have any special problems not listed? Explain:	Yes    No	
11. Have you ever been advised by your physician to take an antibiotic prior to any dental treatments? If yes, antibiotic name and method:	Yes    No	
12. Do you use tobacco? (smoking or chewing)	Yes    No	
13. What is your approximate height?		
<b>14. WOMEN</b>		
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"/>	TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY LUNG DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	ATTENTION DEFICIT DIS.
<input type="checkbox"/>	<input type="checkbox"/>	ENDOCARDITIS	<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY TROUBLE
<input type="checkbox"/>	<input type="checkbox"/>	HEART CONDITION	<input type="checkbox"/>	<input type="checkbox"/>	LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	LIVER DISEASE
<input type="checkbox"/>	<input type="checkbox"/>	HEART PACEMAKER	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS (type? _____)	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC TREATMENT
<input type="checkbox"/>	<input type="checkbox"/>	HEART ANGINA	<input type="checkbox"/>	<input type="checkbox"/>	VENEREAL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	DRUG ADDICTION
<input type="checkbox"/>	<input type="checkbox"/>	HEART ATTACK (CORONARY)	<input type="checkbox"/>	<input type="checkbox"/>	HERPES (ORAL-COLD SORES)	<input type="checkbox"/>	<input type="checkbox"/>	HEADACHES
<input type="checkbox"/>	<input type="checkbox"/>	MITRAL VALVE PROLAPSE	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD DISORDERS/BLEEDING PROB.	<input type="checkbox"/>	<input type="checkbox"/>	EAR ACHES
<input type="checkbox"/>	<input type="checkbox"/>	CONGENITAL HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	INFLAMMATORY RHEUMATISM	<input type="checkbox"/>	<input type="checkbox"/>	JAW CLICKING
<input type="checkbox"/>	<input type="checkbox"/>	ARTIFICIAL HEART VALVE	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES
<input type="checkbox"/>	<input type="checkbox"/>	HEART SURGERY: date: _____	<input type="checkbox"/>	<input type="checkbox"/>	ULCERS	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES TO METAL
<input type="checkbox"/>	<input type="checkbox"/>	HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	STROKE	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES TO LATEX
<input type="checkbox"/>	<input type="checkbox"/>	RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>	JAW PAIN
<input type="checkbox"/>	<input type="checkbox"/>	PROSTHETIC (ARTIFICIAL) JOINT	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	TONSILLITIS
<input type="checkbox"/>	<input type="checkbox"/>	X-RAY/RADIATION (CANCER) THERAPY	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>	EMOTIONAL PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	AIDS OR H.I.V. POSITIVE	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD TRANSFUSIONS
<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	FAINTING SPELLS	<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____

**MEMO:**

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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 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 / Treatment Coordinator  _____	Today's Date _____  Update _____ Initial _____  Update _____ Initial _____  Update _____ Initial _____  Update _____ Initial _____
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**NOTES:**

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