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: DOB: Name: 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, bisphophonates 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?			
14.	WOMEN 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	
☐	☐	TUBERCULOSIS	☐	☐	RESPIRATORY LUNG DISEASE	☐	☐	ATTENTION DEFICIT DIS.
☐	☐	ENDOCARDITIS	☐	☐	HIGH BLOOD PRESSURE	☐	☐	KIDNEY TROUBLE
☐	☐	HEART CONDITION	☐	☐	LOW BLOOD PRESSURE	☐	☐	LIVER DISEASE
☐	☐	HEART PACEMAKER	☐	☐	HEPATITIS (type?_________)	☐	☐	PSYCHIATRIC TREATMENT
☐	☐	HEART ANGINA	☐	☐	VENEREAL DISEASE	☐	☐	DRUG ADDICTION
☐	☐	HEART ATTACK (CORONARY)	☐	☐	HERPES (ORAL-COLD SORES)	☐	☐	HEADACHES
☐	☐	MITRAL VALVE PROLAPSE	☐	☐	BLOOD DISORDERS/BLEEDING PROB.	☐	☐	EARACHES
☐	☐	CONGENITAL HEART DISEASE	☐	☐	INFLAMMATORY RHEUMATISM	☐	☐	JAW CLICKING
☐	☐	ARTIFICIAL HEART VALVE	☐	☐	ARTHRITIS	☐	☐	ALLERGIES
☐	☐	HEART SURGERY: date:__________	☐	☐	ULCERS	☐	☐	ALLERGIES TO METAL
☐	☐	HEART MURMUR	☐	☐	STROKE	☐	☐	ALLERGIES TO LATEX
☐	☐	RHEUMATIC FEVER	☐	☐	ANEMIA	☐	☐	JAW PAIN
☐	☐	PROSTHETIC (ARTIFICIAL) JOINT	☐	☐	ASTHMA	☐	☐	TONSILLITIS
☐	☐	X-RAY/RADIATION (CANCER) THERAPY	☐	☐	EPILEPSY	☐	☐	EMOTIONAL PROBLEMS
☐	☐	AIDS OR H.I.V. POSITIVE	☐	☐	GLAUCOMA	☐	☐	BLOOD TRANSFUSIONS
☐	☐	DIABETES	☐	☐	FAINTING SPELLS	☐	☐	OTHER ______________

MEMO:

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 __________

NOTES: