Medical/Dental History --Adult

Date: ______________________

Patient's Name: ______________________ Sex: ________ Age: ________ Birthdate: ________

Prefers to be addressed by: ______________________ Referred by: ______________________

Address: ______________________ City: ____________ State: ________ Zip: ________

Phone: ______________ Email address: ______________________

Employed by: ______________________ Occupation: ______________________

Work Phone: ______________ Cell Phone: ______________ SS#: ______________

Marital Status: Married Single Divorced Separated Widowed

Spouse's Name: ______________________ Occupation: ____________ Work Phone: ________

Spouse's Employer: ______________________ Cell Phone: ____________ SS#: ____________

Children in Practice Names

Name: ______________________ DOB: ________ Name: ______________________ DOB: ________

Name: ______________________ DOB: ________ Name: ______________________ DOB: ________

Person Responsible for Account: Self Spouse Other (State Name): ______________________

SS#: ____________ Address: ______________________ Business Phone: ______________

Home Phone: ______________ Cell Phone: ______________________

DENTAL INSURANCE

Primary Insurance Co.: ______________________ ID #: ______________ Ortho Coverage: Yes NO

Insured's Name: ______________________ SS#: ______________ Birthdate: ________ Gr. #:________

Secondary Insurance Co.: ______________________ ID #: ______________ Ortho Coverage: Yes NO

Insured's Name: ______________________ SS#: ______________ Birthdate: ________ Gr. #:________

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: NO Bad Bite TMJ Periodontal disease
   If so, by whom? ______________________
7. Do you have any speech problems? YES NO
8. Are you frightened or anxious about Orthodontic treatment? YES NO
9. Are you concerned about the appearance of your teeth? YES NO
10. Is there anything you would like to change about your smile? YES NO
    If so, what: ______________________
11. What aspect of dental treatment are you most concerned with? Quality Cost Discomfort Time
12. **Reason for consultation:**
    ____
13. Has there ever been any orthodontic treatment for any other member of your family? YES NO
    Were they satisfied with the results? YES NO

Sons (Dr. ____________) Daughters (Dr. ____________) Brothers (Dr. ____________) Sisters (Dr. ____________)

MEDICAL HISTORY

1. Is your general health good at this time? YES NO
2. What is the name of your family physician? ___________________________ Date of last physical: ______________________
3. Are you under the care of a physician at this time? YES NO
   Explain: ____
4. Are you taking any medication? YES NO
   Name: ____
5. Are you allergic to any medication? (Penicillin, Sulfa, etc.) YES NO
   Name: ____
6. Have you ever your had tonsils and adenoids removed? YES NO
   Age: ____
7. Have you ever had a serious illness or been hospitalized? YES NO
   Explain: ____
8. Do you have any special problems not listed? YES NO
   Explain: ____
9. Have you ever been advised by your physician to take an antibiotic prior to any dental treatments? YES NO
   If yes, antibiotic name and method: ____
10. What is your approximate height? _________________________________ Weight? __________________________________
11. 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? Circle Yes or No

			MEMO:
Y N Endocarditis	**Y N** Respiratory Lung disease	**Y N** Glaucoma	
Y N Heart Condition	**Y N** High Blood Pressure	**Y N** Fainting Spells	____________________
Y N Heart Pacemaker	**Y N** Low Blood Pressure	**Y N** Kidney Trouble	____________________
Y N Heart Angina	**Y N** Hepatitis (Type?_______)	**Y N** Liver Disease	____________________
Y N Heart Attack (coronary)	**Y N** Tuberculosis	**Y N** Psychiatric Treatment	____________________
Y N Mitral Valve Prolapse	**Y N** Venereal Disease	**Y N** Drug Addiction	____________________
Y N Congenital Heart Disease	**Y N** Herpes (oral-cold sores)	**Y N** Headaches	____________________
Y N Artificial Heart Valve	**Y N** Blood Disorders/Bleeding Problems	**Y N** Earaches	____________________
Y N Heart Surgery; date_______	**Y N** Inflammatory Rheumatism	**Y N** Jaw Clicking	
Y N Heart Murmur	**Y N** Arthritis	**Y N** Allergies	
Y N Rheumatic Fever	**Y N** Ulcers	**Y N** Allergies to Metal	
Y N Prosthetic (artificial) joint	**Y N** Stroke	**Y N** Jaw Pain	
Y N X-ray/Radiation (cancer) Therapy	**Y N** Anemia	**Y N** Tonsillitis	
Y N AIDS or H.I.V. Positive	**Y N** Asthma	**Y N** Emotional Problems	
Y N Diabetes	**Y N** Epilepsy	Other: ____________________	

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 NOT DISCLOSED.

Signature of patient

____

Signature of Dentist

____

Today's Date____________________________________

Update ________________________________ Initial _______

Update ________________________________ Initial _______

Update ________________________________ Initial _______

NOTES: ____