

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 YES NO
an antibiotic prior to any dental treatments?
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

- | | | |
|--------------------------------------|---------------------------------------|---------------------------|
| 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: _____ |

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 NOT DISCLOSED.

Signature of patient	Today's Date _____
_____	Update _____ Initial _____
Signature of Orthodontist	Update _____ Initial _____
_____	Update _____ Initial _____

NOTES: _____

