MEDICAL/DENTAL HISTORY FORM – PATIENTS AGE 18 AND OVER

PATIENT

Date: _____

Patient's Last Name: _____ First Name: _____ MI: _____

Prefers To Be Called: _____ Occupation: _____

Birth Date: _____ Sex: ☐ Male ☐ Female Social Security # _____ - _____ - _____

E-mail: _____

Home Address: _____ City, State, ZIP: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Appointment Reminders: ☐ Text ☐ Phone ☐ E-mail Number/E-mail: _____

DENTIST

Patient's Dentist: _____ City, State: _____

Date of Last Exam/Cleaning: _____ Is there any work to be completed at this time? ☐ Yes ☐ No

If "Yes," please explain: _____

GENERAL INFORMATION

What concerns you most about your teeth? _____

How do you feel about orthodontic treatment? _____

How often do you brush? _____ Floss? _____

Who suggested that you might need orthodontic treatment? _____

How did you hear about our office (e.g. dentist referral, drive-by, internet)? _____

Describe any previous orthodontic treatment/consultations: _____

_____

Have any family members been treated in this office? _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____

Home Address: _____ City, State, ZIP: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

E-mail: _____ Social Security # _____ - _____ - _____

Who will be responsible for bringing the patient to orthodontic appointments? _____

DENTAL INSURANCE

Primary Policy Holder's Full Name: _____ Birth Date: _____

Social Security # _____ - _____ - _____ Relationship to Patient: _____

Home Address: _____ City, State, ZIP: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Secondary Policy Holder's Full Name: _____ Birth Date: _____

Social Security # _____ - _____ - _____ Relationship to Patient: _____

Home Address: _____ City, State, ZIP: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

PHYSICIAN

Patient's Physician: _____ City, State: _____

Last Seen: _____ Reason: _____

Other current health care providers: _____

_____

MEDICAL HISTORY

A thorough medical history is essential to a complete orthodontic evaluation. Your answers are completely confidential. ***For the following questions, please mark yes, no, or don't know/understand (dk/u).***

Now or in the past, have you had:

☐ yes ☐ no ☐ dk/u Birth defects or hereditary problems?
☐ yes ☐ no ☐ dk/u Bone fractures, or major injuries?
☐ yes ☐ no ☐ dk/u Any injuries to face, head, or neck?
☐ yes ☐ no ☐ dk/u Arthritis or joint problems?
☐ yes ☐ no ☐ dk/u Cancer or tumors?
☐ yes ☐ no ☐ dk/u Radiation treatment or chemotherapy?
☐ yes ☐ no ☐ dk/u Endocrine or thyroid problems?
☐ yes ☐ no ☐ dk/u Diabetes or low sugar?
☐ yes ☐ no ☐ dk/u Kidney problems?
☐ yes ☐ no ☐ dk/u Immune system problems?
☐ yes ☐ no ☐ dk/u History of osteoporosis?
☐ yes ☐ no ☐ dk/u Gonorrhea, syphilis, herpes, other STDs?
☐ yes ☐ no ☐ dk/u AIDS or HIV positive?
☐ yes ☐ no ☐ dk/u Hepatitis, jaundice, or other live problems?
☐ yes ☐ no ☐ dk/u Polio, mononucleosis, tuberculosis, pneumonia?
☐ yes ☐ no ☐ dk/u Seizures, fainting spells, neurologic problem?
☐ yes ☐ no ☐ dk/u Mental health disturbance or depression?
☐ yes ☐ no ☐ dk/u History of eating disorder (anorexia, bulimia)
☐ yes ☐ no ☐ dk/u Frequent headaches or migraines?
☐ yes ☐ no ☐ dk/u High or low blood pressure?
☐ yes ☐ no ☐ dk/u Excessive bleeding or bruising tendency, anemia?
☐ yes ☐ no ☐ dk/u Chest pain, shortness of breath, swollen ankles?
☐ yes ☐ no ☐ dk/u Heart defects, heart murmur, rheumatic heart disease?
☐ yes ☐ no ☐ dk/u Angina, arteriosclerosis, stroke, or heart attack?
☐ yes ☐ no ☐ dk/u Skin disorder (other than common acne)?
☐ yes ☐ no ☐ dk/u A poorly balanced diet?
☐ yes ☐ no ☐ dk/u Vision, hearing, or speech problems?
☐ yes ☐ no ☐ dk/u Frequent ear infections, throat infections, or colds?
☐ yes ☐ no ☐ dk/u Asthma, sinus problems, hay fever?
☐ yes ☐ no ☐ dk/u Tonsil or adenoid condition?
☐ yes ☐ no ☐ dk/u Frequent mouth breathing?

☐ yes ☐ no ☐ dk/u Has your child ever taken IV bisphosphonates, such as Zometa (zolendromic acid), Aredia (pamidronate), Didronel (etidronate) for bone disorders or cancer?
☐ yes ☐ no ☐ dk/u Has your child ever taken oral bisphosphonate, such as Fosamax (alendronate), Actonel (ridendronate), Boniva (etidronate) for bone disorders?

Have you had allergies or reactions to any of the following?

☐ yes ☐ no ☐ dk/u Local anesthetics (e.g. novocaine, lidocaine)
☐ yes ☐ no ☐ dk/u Latex (gloves, balloons)
☐ yes ☐ no ☐ dk/u Aspirin
☐ yes ☐ no ☐ dk/u Ibuprofen (Motrin, Advil)
☐ yes ☐ no ☐ dk/u Penicillin
☐ yes ☐ no ☐ dk/u Other antibiotics
☐ yes ☐ no ☐ dk/u Metals (jewelry, clothing snaps)
☐ yes ☐ no ☐ dk/u Acrylics
☐ yes ☐ no ☐ dk/u Plant pollens
☐ yes ☐ no ☐ dk/u Animals
☐ yes ☐ no ☐ dk/u Foods
☐ yes ☐ no ☐ dk/u Other substances

DENTAL HISTORY

Now or in the past, have you had:

☐ yes ☐ no ☐ dk/u Erupting teeth very early or very late?
☐ yes ☐ no ☐ dk/u Primary (baby) teeth removed?
☐ yes ☐ no ☐ dk/u Permanent or extra (supernumerary) teeth removed?
☐ yes ☐ no ☐ dk/u Supernumerary (extra) or congenitally missing teeth?
☐ yes ☐ no ☐ dk/u Chipped or injured permanent teeth?
☐ yes ☐ no ☐ dk/u Any sensitive or sore teeth?
☐ yes ☐ no ☐ dk/u Any lost or broken fillings?
☐ yes ☐ no ☐ dk/u Jaw fractures, cysts, infections?
☐ yes ☐ no ☐ dk/u Any teeth treated with root canals or pulpotomies?
☐ yes ☐ no ☐ dk/u Frequent canker sores or cold sores?
☐ yes ☐ no ☐ dk/u History of speech problems or speech therapy?
☐ yes ☐ no ☐ dk/u Difficulty breathing through nose?
☐ yes ☐ no ☐ dk/u Mouth breathing habit or snoring at night?
☐ yes ☐ no ☐ dk/u History of speech problems?
☐ yes ☐ no ☐ dk/u Frequent oral habits (sucking finger, chewing pen)?
☐ yes ☐ no ☐ dk/u Teeth causing irritation to lip, cheek, or gums?
☐ yes ☐ no ☐ dk/u Tooth-grinding or clenching?
☐ yes ☐ no ☐ dk/u Clicking, locking in jaw joints?
☐ yes ☐ no ☐ dk/u Soreness in jaw muscles or face muscles?
☐ yes ☐ no ☐ dk/u Treatment for "TMJ" or "TMD" problems?
☐ yes ☐ no ☐ dk/u Any broken or missing fillings?
☐ yes ☐ no ☐ dk/u Any trouble with previous dental treatment?
☐ yes ☐ no ☐ dk/u A diagnosis of gum disease?

PATIENT HEALTH INFORMATION

Do you think that any of your activities affect your face, teeth, or jaws? _____

_____

List any medications, nutritional supplements, herbal medications, or non-prescription medicines, including fluoride supplements that you take:

Medication: _____ Taken For: _____

Medication: _____ Taken For: _____

Medication: _____ Taken For: _____

Do you take antibiotic pre-medication before any dental procedures? ☐ Yes ☐ No

Do you currently have (or have ever had) a substance abuse problem? ☐ Yes ☐ No

Do you chew or smoke tobacco? _____

Have you noticed any unusual changes in your face or jaws? _____

Any other physical problems? _____

FAMILY MEDICAL HISTORY

Have your parents or siblings had any of the following health problems? If so, please explain:

Bleeding disorders: _____ Unusual dental problems: _____

Diabetes: _____ Jaw size imbalance: _____

Arthritis: _____ Other conditions: _____

RELEASE AND WAIVER

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. I will notify my orthodontist of any changes in my medical or dental health.

Patient Signature: _____ Date: _____

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Patient Signature: _____ Date: _____