



Date _____

MEDICAL DENTAL HISTORY FORM FOR ADULT PATIENTS

CONFIDENTIAL

PATIENT

Last name _____ First name _____ Middle initial _____

Birth date _____ Name I prefer to be called _____

What sex were you assigned at birth? Male ☐ Female ☐ SS# _____

Home address _____

City/State/Zip _____

Cell phone number _____ Email address _____

Marital Status Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Occupation _____ Employer _____

CLOSEST RELATIVE

Name of spouse/closest relative _____ Relationship to you _____

Phone number (if different from yours) _____

Address (if different from yours) _____

City/State/Zip (if different than yours) _____

DENTIST

Dentist _____ Phone number _____

Dentist's address _____

City/State/Zip _____

Date last seen _____ Reason _____

PHYSICIAN

Physician _____ Phone number _____

Physician's address _____

City/State/Zip _____

Other physicians/health care providers being seen now:

Name _____ City/State _____ Reason _____

Name _____ City/State _____ Reason _____

GENERAL INFORMATION

What concerns you about your teeth? _____

Who suggested that you might need orthodontic treatment? _____

Why did you select our office? _____

Have you had any previous orthodontic treatment? Please describe _____

Have any other family members been treated in this office? Please name _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account?

Last name _____ First name _____ Middle initial _____

Address (if different from yours) _____

City/State/Zip (if different than yours) _____

Email address _____ Cell phone _____

Employer _____ SS# _____

DENTAL INSURANCE

Primary policy holder's name _____ Date of birth _____

SS# _____ Employer _____

Insurance company _____ Group number _____

Does this policy have orthodontic benefits? Yes ☐ No ☐ Don't know ☐

Secondary policy holder's name _____ Date of birth _____

SS# _____ Employer _____

Insurance company _____ Group number _____

Does this policy have orthodontic benefits? Yes ☐ No ☐ Don't know ☐

For the following questions, mark yes, no, or don't know/understand (dk/u). Your answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

DENTAL HISTORY

Now or in the past, have you had:

- ☐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 primary or permanent teeth?
- ☐yes ☐no ☐dk/u Any sensitive or sore teeth?
- ☐yes ☐no ☐dk/u Bleeding gums, bad taste, or mouth odor?
- ☐yes ☐no ☐dk/u Jaw fractures, cysts, infections?
- ☐yes ☐no ☐dk/u Any teeth treated with root canals or pulpotomies?
- ☐yes ☐no ☐dk/u "Gum boils," 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 Food impaction between the teeth?
- ☐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, etc.)?
- ☐yes ☐no ☐dk/u Teeth causing irritation to lip, cheek, or gums?
- ☐yes ☐no ☐dk/u Abnormal swallowing (tongue thrust)?
- ☐yes ☐no ☐dk/u Tooth grinding or clenching?
- ☐yes ☐no ☐dk/u Clicking or locking in jaw joints?
- ☐yes ☐no ☐dk/u Soreness in jaw muscles or face muscles?
- ☐yes ☐no ☐dk/u Ringing in ears, difficulty in chewing or opening jaw?
- ☐yes ☐no ☐dk/u Been treated for "TMJ" or "TMD" problems?
- ☐yes ☐no ☐dk/u Any broken or missing fillings?
- ☐yes ☐no ☐dk/u Any serious trouble associated with previous dental treatment?
- ☐yes ☐no ☐dk/u Been diagnosed with gum disease or pyorrhea?
- ☐yes ☐no ☐dk/u Have you ever had an orthodontic consultation or treatment before now?

MEDICAL HISTORY

Now or in the past, have you had:

- | | | | |
|--|---|--|--|
| ☐ yes ☐ no ☐ dk/u | Have you ever taken IV medication for bone disorders or cancer such as bisphosphonates Zometa (zoledronic acid), Aredia (pamidronate) or Didronel (etidronate)? | ☐ yes ☐ no ☐ dk/u | History of eating disorder (anorexia, bulimia)? |
| ☐ yes ☐ no ☐ dk/u | Have you ever taken oral medication for bone disorders such as bisphosphonates Fosamax (alendronate), Actonel (risedronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate)? | ☐ yes ☐ no ☐ dk/u | High or low blood pressure? |
| ☐ yes ☐ no ☐ dk/u | Heredity or developmental conditions? | ☐ yes ☐ no ☐ dk/u | Excessive bleeding or bruising, or anemia? |
| ☐ yes ☐ no ☐ dk/u | Bone fractures or any major injuries? | ☐ yes ☐ no ☐ dk/u | Chest pain, shortness of breath, tire easily, or swollen ankles? |
| ☐ yes ☐ no ☐ dk/u | Any injuries to face, head, or neck? | ☐ yes ☐ no ☐ dk/u | Heart defects, heart murmur, or rheumatic heart disease? |
| ☐ yes ☐ no ☐ dk/u | Arthritis or joint problems? | ☐ yes ☐ no ☐ dk/u | Angina, arteriosclerosis, stroke, or heart attack? |
| ☐ yes ☐ no ☐ dk/u | Endocrine or thyroid problems? | ☐ yes ☐ no ☐ dk/u | Skin disorder (other than acne)? |
| ☐ yes ☐ no ☐ dk/u | Diabetes or low sugar? | ☐ yes ☐ no ☐ dk/u | Do you eat a well-balanced diet? |
| ☐ yes ☐ no ☐ dk/u | Kidney problems? | ☐ yes ☐ no ☐ dk/u | Frequent headaches or migraines? |
| ☐ yes ☐ no ☐ dk/u | Cancer, tumor, radiation treatment, or chemotherapy? | ☐ yes ☐ no ☐ dk/u | Frequent ear infections, colds, or throat infections? |
| ☐ yes ☐ no ☐ dk/u | Stomach ulcer, hyperacidity, acid reflux? | ☐ yes ☐ no ☐ dk/u | Asthma, sinus problems, or hay fever? |
| ☐ yes ☐ no ☐ dk/u | Immune system problems? | ☐ yes ☐ no ☐ dk/u | Tonsil or adenoid condition? |
| ☐ yes ☐ no ☐ dk/u | History of osteoporosis? | ☐ yes ☐ no ☐ dk/u | Do you frequently breathe through your mouth? |
| ☐ yes ☐ no ☐ dk/u | Gonorrhea, syphilis, herpes, or any sexually transmitted diseases? | Allergies or reactions to any of the following? | |
| ☐ yes ☐ no ☐ dk/u | AIDS or HIV positive? | ☐ yes ☐ no ☐ dk/u | Latex (gloves, balloons) |
| ☐ yes ☐ no ☐ dk/u | Hepatitis, jaundice, or other liver problem? | ☐ yes ☐ no ☐ dk/u | Metals (jewelry, clothing snaps) |
| ☐ yes ☐ no ☐ dk/u | Polio, mononucleosis, tuberculosis, or pneumonia? | ☐ yes ☐ no ☐ dk/u | Acrylics |
| ☐ yes ☐ no ☐ dk/u | Seizures, fainting spells, or neurological problems? | ☐ yes ☐ no ☐ dk/u | Local anesthetics (novocaine, lidocaine, xylocaine) |
| ☐ yes ☐ no ☐ dk/u | Mental health disturbance or depression? | ☐ yes ☐ no ☐ dk/u | Aspirin |
| ☐ yes ☐ no ☐ dk/u | Vision, hearing, or speech problems? | ☐ yes ☐ no ☐ dk/u | Ibuprofen (Motrin, Advil) |
| | | ☐ yes ☐ no ☐ dk/u | Penicillin |
| | | ☐ yes ☐ no ☐ dk/u | Other antibiotics |
| | | ☐ yes ☐ no ☐ dk/u | Plant pollens |
| | | ☐ yes ☐ no ☐ dk/u | Animals |
| | | ☐ yes ☐ no ☐ dk/u | Foods |
| | | ☐ yes ☐ no ☐ dk/u | Other substance _____ |

FAMILY MEDICAL HISTORY

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

Bleeding disorders _____

Diabetes _____

Arthritis _____

Severe allergies _____

Unusual dental problems _____

Jaw size imbalance _____

Other family medical conditions _____

PATIENT HEALTH INFORMATION

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

Medication _____ Taken for _____ Medication _____ Taken for _____

Medication _____ Taken for _____ Medication _____ Taken for _____

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

Have you ever taken any medication to strengthen your bones? Please describe _____

Do you or have you ever had a substance abuse problem? Please explain _____

Have you chewed tobacco? Yes ☐ No ☐ Have you smoked any substance or vaped? Yes ☐ No ☐

If yes, what is the frequency? _____

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

Any other physical problems? _____

How often do you brush? _____ How often do you floss? _____

WOMEN ONLY: Are you pregnant? Yes ☐ No ☐ Are you trying to become pregnant? Yes ☐ No ☐

RELEASE AND WAIVER

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

Signature _____ Date _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her 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.

Signature _____ Date _____

MEDICAL HISTORY UPDATE OR CHANGES

Changes _____

Patient signature _____ Date signed: _____

Dental staff signature _____ Date signed: _____

Changes _____

Patient signature _____ Date signed: _____

Dental staff signature _____ Date signed: _____

Changes _____

Patient signature _____ Date signed: _____

Dental staff signature _____ Date signed: _____