Medical/Dental History - Adult

Date: _____

Patient's Name: _____ Sex: _____ Age: _____ Birthdate: _____

Prefers to be addressed by: _____ Referred by: _____

Address: _____ City: _____ Zip: _____ Phone: _____

Employed by: _____ Occupation: _____ Work Phone: _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: _____ Occupation: _____ Work Phone: _____

Employed by: _____ Child's Name DOB: _____ Child's Name: DOB: _____

Person Responsible for Account
❑ Self ❑ Spouse ❑ Other: _____ SS#: _____

Address: _____ Business Phone _____ Home Phone: _____

DENTAL INSURANCE

Primary Insurance Co: _____ Gr. #: _____ Ortho Coverage: ❑ Yes ❑ No

Insureds Name: _____ SS#: _____ Birthdate: _____

Secondary Insurance Co: _____ Gr. #: _____ Ortho Coverage: ❑ Yes ❑ No

Insureds Name: _____ 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?: ❑ NO
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 (Chief Concern):
13. Has there ever been any orthodontic treatment for any other member of the family? ❑ YES ❑ NO
    Were you satisfied with the results: ❑ YES ❑ NO

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

MEDICAL HISTORY

COMMENTS:

1.	Is your general health good at this time?	❑ YES ❑ NO
2.	Are you under the care of a physician at this time? Explain:	❑ YES ❑ NO
3.	What is the name of your family physician?	Date of last physical:
4.	Are you taking any medication? Name:	❑ YES ❑ NO
5.	Are you allergic to any medication? (Penicillin, Sulfa, etc.) Name:	❑ YES ❑ NO
6.	Have you ever had a serious illness or been hospitalized? Explain:	❑ YES ❑ NO
7.	Have you had tonsils and/or adenoids removed? Age:	❑ YES ❑ NO
8.	Do you have any special problems not listed? Explain:	❑ YES ❑ NO
9.	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
10.	What is your approximate height?	Weight?
11.	WOMEN: Are you pregnant or considering pregnancy during the next 2 years? Are you currently taking medication for birth control?	❑ YES ❑ NO Are you nursing? ❑ YES ❑ NO ❑ 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	❑	❑	ADD
❑	❑	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 PROBLEMS	❑	❑	EARACHES
❑	❑	CONGENITAL HEART DISEASE	❑	❑	INFLAMMATORY RHEUMATISM	❑	❑	JAW CLICKING
❑	❑	ARTIFICIAL HEART VALVE	❑	❑	ARTHRITIS	❑	❑	ALLERGIES
❑	❑	HEART SURGERY; date_____	❑	❑	ULCERS	❑	❑	ALLERGIES TO METAL
❑	❑	HEART MURMUR	❑	❑	STROKE	❑	❑	JAW PAIN
❑	❑	RHEUMATIC FEVER	❑	❑	ANEMIA	❑	❑	TONSILLITIS
❑	❑	PROSTHETIC (ARTIFICIAL) JOINT	❑	❑	ASTHMA	❑	❑	EMOTIONAL PROBLEMS
❑	❑	X-RAY/RADIATION (CANCER) THERAPY	❑	❑	EPILEPSY	❑	❑	OTHER:_____
❑	❑	AIDS OR H.I.V. POSITIVE	❑	❑	GLAUCOMA			
❑	❑	DIABETES	❑	❑	FAINTING SPELLS			

MEMO:

_____
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_____

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 _____

Update _____ Initial _____

NOTES:

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