Medical/Dental History - Adult

Date: ____/____/____ Who may we thank for referring you?:

Patient's Name: Sex: M / F Age: Birthdate: / /

Prefers to be addressed as: Phone #: Cell #:

Address: City: State: Zip: Email Address:

Employed by: Occupation: Work Phone:

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

Spouse's Name: Occupation: Work Phone:

Employed by: If Children, Name: DOB: / / Name: DOB: / /

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

Address: Business Phone: Cell #:

Contact in case of Emergency: Name: Phone #: Cell #:

DENTAL INSURANCE

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

Insured's Name: SS #: Birthdate:

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

Insured's Name: SS #: Birthdate: / /

Other Insurance Information:

DENTAL HISTORY

Patient Dentist Name: 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? ❑ 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 ❑ None
   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 (chief concern):
13. Has there ever been any orthodontic treatment for any other member of your family? ❑ YES ❑ NO Stage of TX:
    Were they satisfied with the results? ❑ YES ❑ NO

Children (Dr.) Spouse (Dr.) Other Family Members (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 taken any diet medication (Fen-Phen)?	❑ YES ❑ NO
7.	Have you ever had a serious illness or been hospitalized? Explain:	❑ YES ❑ NO
8.	Have you had your tonsils and/or adenoids removed? Age:	❑ YES ❑ NO
9.	Do you have any special problems not listed? Explain:	❑ YES ❑ NO
10.	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 Pharmacy:
11.	Do you use tobacco? (smoking or chewing)	❑ YES ❑ NO
12.	What is your approximate height?	Weight?
13.	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	❑	❑	DIABETES	❑	❑	ADD
❑	❑	ENDOCARDITIS	❑	❑	RESPIRATORY LUNG DISEASE	❑	❑	KIDNEY TROUBLE
❑	❑	HEART CONDITION	❑	❑	HIGH BLOOD PRESSURE	❑	❑	LIVER DISEASE
❑	❑	HEART PACEMAKER	❑	❑	LOW BLOOD PRESSURE	❑	❑	PSYCHIATRIC TREATMENT
❑	❑	HEART ANGINA	❑	❑	HEPATITIS (type?_____)	❑	❑	DRUG ADDICTION
❑	❑	HEART ATTACK (CORONARY)	❑	❑	VENEREAL DISEASE	❑	❑	HEADACHES
❑	❑	MITRAL VALVE PROLAPSE	❑	❑	HERPES (ORAL-COLD SORES)	❑	❑	EARACHES
❑	❑	CONGENITAL HEART DISEASE	❑	❑	BLOOD DISORDERS/BLEEDING PROBLEMS	❑	❑	JAW CLICKING
❑	❑	ARTIFICIAL HEART VALVE	❑	❑	INFLAMMATORY RHEUMATISM	❑	❑	ALLERGIES
❑	❑	HEART SURGERY; date_____	❑	❑	ULCERS	❑	❑	ALLERGIES TO METAL
❑	❑	HEART MURMUR	❑	❑	STROKE	❑	❑	ALLERGIES TO LATEX
❑	❑	RHEUMATIC FEVER	❑	❑	ANEMIA	❑	❑	JAW PAIN
❑	❑	ARTHRITIS / OSTEOPOROSIS / BISPHOSPHONATES	❑	❑	ASTHMA	❑	❑	TONSILLITIS
❑	❑	PROSTHETIC (ARTIFICIAL) JOINT	❑	❑	EPILEPSY	❑	❑	EMOTIONAL PROBLEMS
❑	❑	X-RAY/RADIATION (CANCER) THERAPY	❑	❑	GLAUCOMA	❑	❑	OTHER:_____
❑	❑	AIDS OR H.I.V. POSITIVE	❑	❑	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. I grant authority to the Doctor and Staff to perform all procedures and treatments in my best interest. I authorize the Orthodontist to share treatment information with collaborating dentists and surgeons when appropriate. I authorize the Orthodontist to submit treatment information pertinent to this patient to the Insurance Company for billing purposes only. I understand that, when appropriate, Credit Bureau reports may be obtained.

Signature of Patient

_____

Signature of Orthodontist

_____

Today's Date _____

Update _____ Initial _____

Update _____ Initial _____

Update _____ Initial _____

Update _____ Initial _____

NOTES:

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