

Medical/Dental History - Adult

Date: _____

Patients 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: _____ Child's Name: _____
DOB: _____ DOB: _____

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

Address: _____ Business Phone: _____ Home Phone: _____

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'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?
Name: _____ Date: _____ YES NO
6. Have you ever been treated for:
If so, by whom? _____ NO Bad Bite TMJ Periodontal disease
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?
If so, what: _____ YES NO
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
Were they satisfied with the results? YES NO Stage of TX: _____

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

MEDICAL HISTORY

COMMENTS:

1.	Is your general health good at this time?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
2.	Are you under the care of a physician at this time? Explain:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
3.	What is the name of your family physician?	Date of last physical:		
4.	Are you taking any medication? Name:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
5.	Are you allergic to any medication? (Penicillin, Sulfa, etc.) Name:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
6.	Have you ever taken any diet medication (Fen-Phen)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
7.	Have you ever had a serious illness or been hospitalized? Explain:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
8.	Have you had your tonsils and/or adenoids removed? Age:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
9.	Do you have any special problems not listed? Explain:	<input type="checkbox"/> YES	<input type="checkbox"/> 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:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Pharmacy:
11.	Do you use tobacco? (smoking or chewing)	<input type="checkbox"/> YES	<input type="checkbox"/> 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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Are you nursing? <input type="checkbox"/> YES <input type="checkbox"/> NO

DO YOU HAVE NOW, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO		YES	NO
TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY LUNG DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCARDITIS	<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>
HEART CONDITION	<input type="checkbox"/>	<input type="checkbox"/>	LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	LIVER DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
HEART PACEMAKER	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS (type? _____)	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC TREATMENT	<input type="checkbox"/>	<input type="checkbox"/>
HEART ANGINA	<input type="checkbox"/>	<input type="checkbox"/>	VENEREAL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	DRUG ADDICTION	<input type="checkbox"/>	<input type="checkbox"/>
HEART ATTACK (CORONARY)	<input type="checkbox"/>	<input type="checkbox"/>	HERPES (ORAL-COLD SORES)	<input type="checkbox"/>	<input type="checkbox"/>	HEADACHES	<input type="checkbox"/>	<input type="checkbox"/>
MITRAL VALVE PROLAPSE	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD DISORDERS/BLEEDING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	EARACHES	<input type="checkbox"/>	<input type="checkbox"/>
CONGENITAL HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	INFLAMMATORY RHEUMATISM	<input type="checkbox"/>	<input type="checkbox"/>	JAW CLICKING	<input type="checkbox"/>	<input type="checkbox"/>
ARTIFICIAL HEART VALVE	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>
HEART SURGERY; date _____	<input type="checkbox"/>	<input type="checkbox"/>	ULCERS	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES TO METAL	<input type="checkbox"/>	<input type="checkbox"/>
HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	STROKE	<input type="checkbox"/>	<input type="checkbox"/>	JAW PAIN	<input type="checkbox"/>	<input type="checkbox"/>
RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>	TONSILLITIS	<input type="checkbox"/>	<input type="checkbox"/>
PROSTHETIC (ARTIFICIAL) JOINT	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	EMOTIONAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
X-RAY/RADIATION (CANCER) THERAPY	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD TRANSFUSION	<input type="checkbox"/>	<input type="checkbox"/>
AIDS OR H.I.V. POSITIVE	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____		
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	FAINTING SPELLS	<input type="checkbox"/>	<input type="checkbox"/>			

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. 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:
