

# 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: \_\_\_\_\_ Child's Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ DOB: \_\_\_\_\_Person Responsible for Account: \_\_\_\_\_ SS#: \_\_\_\_\_  
 Self  Spouse  Other:

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?  YES  NO  
Name: \_\_\_\_\_ Date: \_\_\_\_\_
6. Have you ever been treated for:  Bad Bite  TMJ  Periodontal disease  
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  YES  NO Stage of TX: \_\_\_\_\_  
Were they satisfied with the results?

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?  YES  NO  
Explain: \_\_\_\_\_
3. What is the name of your family physician? \_\_\_\_\_ Date of last physical: \_\_\_\_\_
4. Are you taking any medication?  YES  NO  
Name: \_\_\_\_\_
5. Are you allergic to any medication? (Penicillin, Sulfa, etc.)  YES  NO  
Name: \_\_\_\_\_
6. Have you ever had a serious illness or been hospitalized?  YES  NO  
Explain: \_\_\_\_\_
7. Have you had your tonsils and/or adenoids removed?  YES  NO  
Age: \_\_\_\_\_
8. Do you have any special problems not listed?  YES  NO  
Explain: \_\_\_\_\_
9. Have you ever been advised by your physician to take an antibiotic prior to any dental treatments?  YES  NO  
If yes, antibiotic name and method: \_\_\_\_\_ Pharmacy: \_\_\_\_\_
10. What is your approximate height? \_\_\_\_\_ Weight? \_\_\_\_\_

11. **WOMEN:**  
 Are you pregnant or considering pregnancy during the next 2 years?  YES  NO Are you nursing?  YES  NO  
 Are you currently taking medication for birth control?  YES  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: _____	<input type="checkbox"/>	<input type="checkbox"/>
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 understand that, when appropriate, Credit Bureau reports may be obtained.

In Case of Emergency, Contact:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of Patient \_\_\_\_\_

Signature of Orthodontist \_\_\_\_\_

Today's Date \_\_\_\_\_

Update \_\_\_\_\_ Initial \_\_\_\_\_

Update \_\_\_\_\_ Initial \_\_\_\_\_

Update \_\_\_\_\_ Initial \_\_\_\_\_

Update \_\_\_\_\_ Initial \_\_\_\_\_

Update \_\_\_\_\_ Initial \_\_\_\_\_

**NOTES:**

---

---

---

---

---

---

---

---

---

---