

Adult Patient Dental/Medical History Form

Date: _____

Patient Last Name _____ First _____ Middle _____

Nickname _____ Birthdate _____ Age _____ Gender _____

Best Contact Number _____ Alternate Phone Numbers _____

Patient Address – Street _____

City _____ State _____ Zip _____

Social Security Number _____ Email _____

Responsible Financial Party (if different from above) _____

Address (if different from above) _____

_____ Phone Number _____

Name of Patient's Dentist _____

Dentist's Address _____ Phone Number _____

Name of Physician _____

Physician Address _____ Phone Number _____

Favorite Sports, Hobbies, Avocations _____

Insurance Coverage Yes No

Primary Insurance Coverage _____ Policy Number _____

Secondary Insurance Coverage _____ Policy Number _____

In case we cannot reach you:

Person to contact _____ Phone Number _____

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

yes	no	dk/u	Do you follow directions?
yes	no	dk/u	Do you brush his/her teeth conscientiously?
yes	no	dk/u	Do you have learning disabilities or need extra help with instructions?
yes	no	dk/u	Are you sensitive, self-conscious?

MEDICAL HISTORY

yes no dk/u Bone fractures, any major accidents?

yes no dk/u Rheumatoid or arthritic conditions

yes no dk/u Fainting spells, seizures, epilepsy or neurological problems?

yes no dk/u Kidney problems?

yes no dk/u Problems with immune system?

yes no dk/u AIDS or HIV positive?

yes no dk/u Hepatitis, jaundice, or liver problems?

yes no dk/u Endocrine or thyroid problems?

yes	no	dk/u	Diabetes?	yes	no	dk/u	Cancer or been treated for a tumor?
yes	no	dk/u	Stomach or Ulcer Hypercidity?	yes	no	dk/u	Birth defects or hereditary problems?
yes	no	dk/u	Polio, mono, tuberculosis, pneumonia?	yes	no	dk/u	Operations? Surgical Procedures?
yes	no	dk/u	Mental health or behavioral problem?	yes	no	dk/u	Vision, hearing, tasting, or
yes	no	dk/u	Chest pain, shortness of breath or swelling ankles?	yes	no	dk/u	Speech difficulties?
yes	no	dk/u	Skin Disorder?	yes	no	dk/u	Tires easily?
yes	no	dk/u	Loss of weight recently, poor appetite?	yes	no	dk/u	Do you have a normal or good diet?
yes	no	dk/u	Excessive bleeding, black and blue tendency, anemia or bleeding disorders?	yes	no	dk/u	High or low blood pressure?
yes	no	dk/u	Frequent headaches, colds, sore throats?	yes	no	dk/u	Eye, ear, nose, throat condition?
yes	no	dk/u	Cardiovascular problems? _____	yes	no	dk/u	Hayfever, asthma, sinus trouble?
yes	no	dk/u	Tonsil or adenoid conditions?	yes	no	dk/u	Allergies or drug reactions?
yes	no	dk/u	Are you taking medications, nutrient supplements, or or non-prescription medicine? Please name them: _____ _____	yes	no	dk/u	Do you currently have or or ever had a substance abuse problem?
yes	no	dk/u	Hospitalized for _____	yes	no	dk/u	Other physical problems or symptoms?
yes	no	dk/u	Being treated by another health care professional? For _____	yes	no	dk/u	Any form of autoimmune disease?

Date of most recent physical exam? _____

DENTAL HISTORY

yes	no	dk/u	Started teeth very early or late?	yes	no	dk/u	Abnormal swallowing habit?
yes	no	dk/u	Permanent or "extra" (supernumerary) teeth removed?	yes	no	dk/u	Jaw fractures, cysts, mouth infections?
yes	no	dk/u	Supernumerary or congenitally missing teeth?	yes	no	dk/u	"Dead Teeth", root canals treated?
yes	no	dk/u	Teeth sensitive to hot or cold; teeth throb or ache?	yes	no	dk/u	Periodontal "Gum Problems"?
yes	no	dk/u	Bleeding gums, bad taste, mouth odor?	yes	no	dk/u	Food impaction between teeth?
yes	no	dk/u	Mouth breathing habit, snoring, difficulty in breathing?	yes	no	dk/u	"Gum Boils," frequent canker sores, cold sore?
yes	no	dk/u	Thumb, finger sucking habit? Until _____	yes	no	dk/u	Any wisdom tooth problems?
yes	no	dk/u	Tooth grinding, jaw clenching, clicking, locking?	yes	no	dk/u	Any pain in jaw, ringing in the ears?
yes	no	dk/u	Does the patient experience any pain, Or soreness in the muscles of the face, Or around the ears?	yes	no	dk/u	Any teeth irritating cheek, lip, tongue?
yes	no	dk/u	Difficulty encountered in chewing or jaw opening?	yes	no	dk/u	Has patient ever had periodontal (gum) treatment?
yes	no	dk/u	Aware of loose, broken or missing restorations (fillings)?	yes	no	dk/u	Would you object to wearing orthodontic appliances (braces) should they be indicated?
yes	no	dk/u	Concerned about spaced, crooked, protruding teeth?				
yes	no	dk/u	Aware or concerned about under or over developed jaw?				
yes	no	dk/u	Any relative with any similar tooth or jaw relationships?				
yes	no	dk/u	Has patient ever had a prior orthodontic examination or treatment?				
yes	no	dk/u	Has patient recently been under another dentist's care? Specialist _____ Other _____				

Date of most recent dental examination _____ How often do you brush teeth _____
Floss _____

What is the patient's (or parent's) primary dental concern?

Realizing that successful treatment greatly depends upon the complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment?

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signature of patient

Date