



Medical / Dental History Form - Adult

PATIENT

Today's Date: ___/___/___

Last Name: _____ First Name: _____ Middle Initial: _____

Prefers to be called: _____ Date of Birth: ___/___/___ Gender: Male Female

Home Address: _____

Cell Phone: () _____ - _____ Cell Carrier: _____ Work Phone: () _____ - _____

Email Address: _____@_____.com

Hobbies and Activities: _____

DENTIST

Dentist: _____ Date of Last Visit: ___/___/___

Reason for last visit: _____

Other dentists/dental specialists now being seen? _____

Reason: _____

DENTAL INSURANCE

Primary Policy holder's full name: _____ Date of Birth: ___/___/___

Social Security #: _____ - _____ - _____ Relationship to Patient: _____

Employer: _____ Address: _____

Insurance Company Name: _____ Group #: _____ ID#: _____

Does this policy have orthodontic benefits? Yes No Don't Know

Secondary Policy holder's full name: _____ Date of Birth: ___/___/___

Social Security #: _____ - _____ - _____ Relationship to Patient: _____

Employer: _____ Address: _____

Insurance Company Name: _____ Group #: _____ ID#: _____

Does this policy have orthodontic benefits? Yes No Don't Know

PATIENT / FAMILY HEALTH INFORMATION

Please list any medication, nutritional supplements, herbal medications, or non-prescription medicines, including fluoride supplements that you take.

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Do you require antibiotic pre-medication before any dental procedures? _____

Do you chew, smoke, or vape any tobacco product? _____

Did your mother and/or father ever have orthodontic treatment? _____

Did your mother and/or father require jaw surgery as part of orthodontic treatment: _____

For the following question, please mark yes, no, or don't know (DK). Please mark each question individually, do NOT draw a line through all answers. Thank you.

Medical History

Now, or in the past, have you had:

- | Yes | No | DK | |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Birth defects or hereditary problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bone fractures of major injuries? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Any injuries to face, head, neck? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis or joint problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Seizures, fainting spells, neurological problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mental health disturbances and/or depression? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent headaches or migraines? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart defects, heart murmur, rheumatic heart disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you frequently breath through your mouth? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever taken intravenous bisphosphanates for bone disorders or cancer? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever taken oral bisphosphanates for bone disorders? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Surgeries: _____ |

Dental History

Now, or in the past, have you had:

- | Yes | No | DK | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Permanent teeth removed? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Congenitally missing teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Presence of extra (supernumerary) teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chipped or injured permanent teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Any sensitive or sore teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Any lost or broken fillings? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Jaw fractures, cysts, or infections? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Any teeth treated with root canals or pulpotomies? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Placement of Dental Implants? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent canker sores or cold sores? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | History or speech problems or speech therapy? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty breathing through nose? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mouth breathing habit or snoring at night? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent oral habits (fingers, thumbs, pens, etc.) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Teeth causing irritation to lip, cheek, or gums? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tooth grinding or clenching? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Clicking, locking of jaw joints? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Soreness in jaw or face muscles? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you been treated for "TMJ" or "TMD" problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Any trouble associated with prior dental treatment? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been diagnosed with periodontal (gum) disease? |

Are you allergic to or suffered reactions to any of the following?

- | Yes | No | DK | |
|--------------------------|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Latex (gloves, balloons) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ibuprofen (Motrin, Advil) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Metals (jewelry, clothing snaps) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Acrylics |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other substances: _____ |

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature: _____ Date: ____/____/____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature: _____ Date: ____/____/____

MEDICAL HISTORY UPDATES OR CHANGES

Changes: _____

Signature: _____ Date: ____/____/____

Staff Signature: _____ Date: ____/____/____