American Association of Orthodontists®

CONFIDENTIAL

Medical Dental History Form for Adult Patients

PATIENT

Date _____

Patient's Last name _____ First name _____ Middle initial _____

Title ☐ Mr. ☐ Mrs. ☐ Miss ☐ Dr. ☐ Other I prefer to be called _____

Birth date _____ Social Security # _____

What sex were you assigned on your birth certificate? ☐ Male ☐ Female

What is your current gender identification? ☐ Male ☐ Female ☐ Other

What are your preferred pronouns? _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home address _____ City, State, Zip code _____

Cell phone _____ Home phone _____

Work phone _____

E-mail address(es) _____

Occupation _____ Employer _____

CLOSEST RELATIVE

Spouse or closest relative's name(s) _____ Relationship to patient _____

Title ☐ Mr. ☐ Mrs. ☐ Miss ☐ Dr. ☐ Other Prefers to be called _____

Address *(if different than patient address)* _____

Cell phone _____ Home phone _____ Work phone _____

DENTIST

Patient's Dentist _____ Address, City, State _____

Last seen _____ Reason _____ Next appointment _____

Other dentists/dental specialists now being seen: Name _____ City, State _____

Reason _____

PHYSICIAN

Patient's Physician _____ City, State _____

Last seen _____ Reason _____ Next appointment _____

Most recent physical exam _____

Other physicians/health care providers being seen now:

Name _____ City, State _____ Reason _____

Name _____ City, State _____ Reason _____