

## 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 | Problems with immune system?            |
| yes | no | dk/u | Rheumatoid or arthritic conditions                            | yes | no | dk/u | AIDS or HIV positive?                   |
| yes | no | dk/u | Fainting spells, seizures, epilepsy or neurological problems? | yes | no | dk/u | Hepatitis, jaundice, or liver problems? |
| yes | no | dk/u | Kidney 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 | Polio, mono, tuberculosis, pneumonia?                         | yes | no | dk/u | Birth defects or hereditary problems?   |

- |     |    |      |  |     |    |      |   |
|-----|----|------|--|-----|----|------|---|
| yes | no | dk/u | Mental health or behavioral problem?   | yes | no | dk/u | Operations? Surgical Procedures?                                |
| yes | no | dk/u | Chest pain, shortness of breath or swelling ankles?  | yes | no | dk/u | Vision, hearing, tasting, or                                    |
| yes | no | dk/u | Skin Disorder?   |     |    |      | Speech difficulties?  |
| yes | no | dk/u | Loss of weight recently, poor appetite?  | yes | no | dk/u | Tires easily?   |
| yes | no | dk/u | Excessive bleeding, black and blue tendency, anemia or bleeding disorders?   | yes | no | dk/u | Do you have a normal or good diet?                              |
| yes | no | dk/u | Frequent headaches, colds, sore throats?   | yes | no | dk/u | High or low blood pressure?                                     |
| yes | no | dk/u | Cardiovascular problems? _____   | yes | no | dk/u | Eye, ear, nose, throat condition?                               |
| yes | no | dk/u | Tonsil or adenoid conditions?  | yes | no | dk/u | Hayfever, asthma, sinus trouble?                                |
| yes | no | dk/u | Are you taking medications, nutrient supplements, or or non-prescription medicine? Please name them:<br>_____<br>_____ | yes | no | dk/u | Allergies or drug reactions?                                    |
|     |    |      |  | 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