Medical/Dental History - Adult

Referred by _____

Date_____

Patient's Name_____Sex:M/F_____Age_____Birthdate_____

Address_____City_____Zip_____Phone_____

Employer_____Occupation_____Work Phone_____

Marital Status (Please Circle) Married Single Divorced Separated Widowed

Spouse's Name_____Occupation_____Work Phone_____

Employer_____

Person Responsible for Account (Please Circle) Father Mother Guardian Other

S.S.#_____Home Phone_____

Address_____Buisness Phone_____Cell Phone_____

Dental Insurance

Primary Insurance Co._____ Gr. #_____

Insureds Name_____S.S. #_____Birthdate_____

Dental History

Patient's Dentist _____ Date of last visit _____

Yes	No	Have there been any injuries to the face, mouth or teeth?
		Have you had or presently have any of the following habits? (Please Circle)
		Thumb or finger sucking
		Lip biting
		Snoring
		Grinding of teeth at night
		Mouth Breathing
Yes	No	Have you been informed of any missing or extra permanent teeth?
Yes	No	Are you aware of sores, lumps or irritated areas in the mouth?
Yes	No	Has an orthodontist been consulted previously?
		Name_____Date_____
Yes	No	Have you ever been treated for: (Please Circle)
		Bad Bite
		TMJ
		Periodontal Disease
		If so, by whom? _____
		When? _____
Yes	No	Do you have any speech problems?
Yes	No	Are you frightened or anxious about Orthodontic treatment?
Yes	No	Are you concerned about the appearance of yout teeth?
Yes	No	Is there anything you would like to change about your smile?
		If so, what? _____
		What aspect of dental treatment are you most concerned with? (Please Circle)
		Cost

Quality
Discomfort
Time
Reason for consultation (Chief Concern) _____

Yes No Has there ever been any orthodontic treatment for any other member of the family?
Mother Dr. _____
Father Dr. _____
Siblings Dr. _____

Yes No Are they satisfied with the results?

Medical History

Yes No Is your general health good at this time?
What is the name of your family physician? _____

Yes No Are you under the care of a physician at this time?
Explain_____

Yes No Are you taking any medication?
Name_____

Yes No Are you allergic to any medication? (Penicillin, Sulfa, etc.)
Name_____

Yes No Have you ever taken any diet medication? (Fen-Phen)

Yes No Have you ever had your tonsils and/or adenoids removed?
Age _____

Yes No Have you ever had a serious illness or been hospitalized? _____
Explain_____

Yes No Do you have any special problems not listed?
Explain_____

Yes No Have you ever been advised by your physician to take an antibiotic prior to any dental treatments?
If yes, name and dosage of medication_____

Yes No Do you use tobacco? (smoking or chewing gum)
What is your approximate height?_____
Weight? _____

WOMEN

Yes No 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?

Do you now, or have you ever had any of the following? (Please Circle)

Tuberculosis
Endocarditis
Heart Condition
Heart Pacemaker
Rheumatic Fever
Heart Angina
Heart Attack (Coronary)
Mitral Valve Prolapse
Congenital Heart Disease
Artificial Heart Valve
Heart Surgery
Heart Murmur
Rheumatic Fever
Prosthetic (Artificial) Joint
Radiation (Cancer) Therapy
AIDS or HIV Positive
Diabetes

Respiratory Lung Disease
High Blood Pressure
Low Blood Pressure
Hepatitis (type?_____)
Venereal Disease
Herpes (Oral-Cold Sores)
Blood Disorders
Inflammatory Rheumatism
Arthritis
Ulcers
Stroke
Anemia
Asthma
Epilepsy
Glaucoma
Fainting Spells

ADD
Kidney Trouble
Liver Disease
Psychiatric Treatment
Drug Addiction
Headaches
Earaches
Jaw Clicking
Allergies
Allergies to Metal
Allergies to Latex
Jaw Pain
Tonsillitis
Emotional Problems
Other_____

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 authorize the Orthodontist to share treatment information with collaborating dentists and surgeons when appropriate. I authorize the Orthodontist to submit treatment information pertinent to this patient to the Insurance Company for billing purposes only. I understand that, when appropriate, Credit Bureau reports may be obtained.

Signature of Patient_____
Signature of Orthodontist_____

Today's
Date_____

Update_____Initial_____
Update_____Initial_____
Update_____Initial_____
Update_____Initial_____

NOTES: