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**Medical Dental History Form
For Patients Over Age 18**

PATIENT

Date _____
Last name _____ First name _____ Middle initial _____
Title Mr. Mrs. Ms. Dr. Other _____ Prefers to be called _____
Hobbies, activities, etc _____
Birth date _____ Sex: Male Female Social Security # _____ - ____ - _____
Marital Status Single Married Separated Divorced Widowed
Home address _____ City _____ State _____ Zip code _____
Home phone (_____) _____ Cell phone (_____) _____ Work phone (_____) _____
E-mail address (es) _____
Occupation _____ Employer _____

CLOSEST RELATIVE

Spouse or closest relatives name (s) _____ Relationship to patient _____
Title Mr. Mrs. Ms. Dr. Other _____ Prefers to be called _____
Address (if different than patient address) _____
Home phone (if different): (_____) _____ Cell phone (_____) _____ Work phone (_____) _____

DENTAL INSURANCE

Primary policy holder's full name _____ Birthdate _____
Social Security # _____ - ____ - _____ Relationship to patient _____
Address and phone (if not listed above) _____
Employer _____ Address _____
Insurance company _____ Group # _____ ID# _____
Does this policy have orthodontic benefits? Yes No Don't know

Secondary policy holder's full name _____ Birthdate _____
Social Security # _____ - ____ - _____ Relationship to patient _____
Address and phone (if not listed above) _____
Employer _____ Address _____
Insurance company _____ Group # _____ ID# _____
Does this policy have orthodontic benefits? Yes No Don't know

FINANCIAL RESPONSIBILITY (If you are financially responsible, check here and leave below blank)

Who is financially responsible for this account? _____
Address (if different than patient address) _____
Home phone (_____) _____ Cell phone (_____) _____ E-mail address(es) _____
Social Security # _____ - _____ - _____ Employer: _____

DENTIST (If patient does not currently see a general dentist please check here)

Patient's Dentist _____ Address _____
Last seen _____ Reason _____
Other dentists/dental specialists now being seen: Name _____ City _____ State _____
Reason _____

GENERAL INFORMATION

What concerns you about your teeth? _____
Who suggested that you might need orthodontic treatment? _____
Why did you select our office? _____
Any previous orthodontic treatment or consultations? Where? _____
Have any other family members been treated in this office? Please name them. _____
Brother/sister name _____ age _____ had orthodontic treatment? Yes No If yes, where? _____
Brother/sister name _____ age _____ had orthodontic treatment? Yes No If yes, where? _____
Brother/sister name _____ age _____ had orthodontic treatment? Yes No If yes, where? _____

MEDICAL INSURANCE

Policy holder's full name _____
Insurance company _____

PHYSICIAN

Patient's Physician _____ Address _____
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 _____

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation. For the following questions mark yes, no or don't know/understand (dk/u).

MEDICAL HISTORY

Now or in the past, have you had:

- yes no dk/u Birth defects or hereditary problems?
yes no dk/u Bone fractures, or major injuries?
yes no dk/u Any injuries to face, head, neck?
yes no dk/u Arthritis or joint problems?
yes no dk/u Endocrine or thyroid problems?
yes no dk/u Diabetes or low sugar?
yes no dk/u Kidney problems?
yes no dk/u Cancer, tumor, radiation treatment or chemotherapy?
yes no dk/u Immune system problems?
yes no dk/u History of osteoporosis?
yes no dk/u Gonorrhea, syphilis, herpes, STD's?
yes no dk/u AIDS or HIV positive?
yes no dk/u Hepatitis, jaundice or other liver problem?
yes no dk/u Polio, mononucleosis, tuberculosis, pneumonia?
yes no dk/u Seizures, fainting spells, neurologic problem?
yes no dk/u Mental health disturbance or depression?
yes no dk/u Vision, hearing, or speech problems?
yes no dk/u History of eating disorder (anorexia, bulimia)?
yes no dk/u High or low blood pressure?
yes no dk/u Excessive bleeding or bruising, anemia?
yes no dk/u Chest pain, short of breath, tire easily, swollen ankles?
yes no dk/u Heart defects, heart murmur, rheumatic heart disease?
yes no dk/u Angina, arteriosclerosis, stroke or heart attack?
yes no dk/u Skin disorder (other than common acne)?
yes no dk/u Do you eat a well-balanced diet?
yes no dk/u Frequent headaches or migraines?
yes no dk/u Frequent ear infections, colds, throat infections?
yes no dk/u Asthma, sinus problems, hayfever?
yes no dk/u Tonsil or adenoid condition?
yes no dk/u Does you frequently breathe through your mouth?
yes no dk/u Has you ever taken intravenous bisphosphonates such as Zometa (zoledromic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?
yes no dk/u Has you ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone Disorders?

Have you had allergies or reactions to any of the following:

- yes no dk/u Local anesthetics (Novocain, lidocaine, xylocaine)
yes no dk/u Latex (gloves, balloons)
yes no dk/u Aspirin
yes no dk/u Ibuprofen (Motrin, Advil)
yes no dk/u Penicillin
yes no dk/u Other antibiotics
yes no dk/u Metal (jewelry, clothing snaps)
yes no dk/u Acrylics
yes no dk/u Plant pollens
yes no dk/u Animals
yes no dk/u Foods
yes no dk/u Other substances _____

DENTAL HISTORY

Now or in the past, have you had:

- yes no dk/u Erupting teeth very early or very late?
yes no dk/u Primary (baby) teeth removed that were not loose?
yes no dk/u Permanent or extra (supernumerary) teeth removed?
yes no dk/u Supernumerary (extra) or congenitally missing teeth?
yes no dk/u Chipped or injured primary or permanent teeth?
yes no dk/u Any sensitive or sore teeth?
yes no dk/u Jaw fractures, cysts, infections?
yes no dk/u Any teeth treated with root canals or pulpotomies?
yes no dk/u "Gum boils," frequent canker sores or cold sores?
yes no dk/u History of speech problems or speech therapy?
yes no dk/u Difficulty breathing through nose?
yes no dk/u Mouth breathing habit or snoring at night?
yes no dk/u History of speech problems?
yes no dk/u Frequent oral habits (sucking finger, chewing pens, etc.)?
yes no dk/u Teeth causing irritation to lip, cheek or gums?
yes no dk/u Tooth grinding or clenching?
yes no dk/u Clicking, locking in jaw joints?
yes no dk/u Soreness in jaw muscles or face muscles?
yes no dk/u Has you been treated for "TMJ" or "TMD" problems?
yes no dk/u Any broken or missing fillings?
yes no dk/u Any serious trouble associate with previous dental treatment?
yes no dk/u Has you ever been diagnosed with gum disease or pyorrhea?
yes no dk/u Have you ever had an orthodontic consultation or treatment before now?

PATIENT HEALTH INFORMATION

Do any of your activities or hobbies affect your face, teeth or jaws? How? _____

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

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Do you currently have (or ever had) a substance abuse problem? _____

Do you chew or smoke tobacco? _____

Have you noticed any unusual changes in your face or jaws? _____

Any other physical problems? _____

FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders _____

Diabetes _____

Arthritis _____

Severe allergies _____

Unusual dental problems _____

Jaw size imbalance _____

Other family medical conditions? _____

How often do you brush? _____

Floss? _____

RELEASE AND WAIVER

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

Patient 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.

Patient Signature _____ Date _____