 **Confidential Medical/**

  **Dental History Form**

**for Adult Patients**



4150 B Douglas Blvd

Granite Bay, CA 95746

Phone: 916-774-6986

# Patient

Date Patient’s last name

First name

Middle initial

Title Mr. Mrs. Ms. Miss. Dr. Other

I prefer to be called

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 ( ) -

Email Address(es)

Occupation

Employer

# Closest Relative

Spouse or closest relative’s name(s)

Title Mr. Mrs. Ms. Miss. Dr. Other

Relationship to patient

Address *(if different than patient address)*

Home Phone *(If different)* ( ) -

Cell 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

# General Information

What concerns you about your teeth? Who suggested that you might need orthodontic treatment? Why did you select our office? Have you had any previous orthodontic treatment? Please describe. Have any other family members been treated in this office? Please name them. Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain.

# Financial Responsibility

Who is financially responsible for this account?

Address *(if different than page 1)*

City, State, Zip

Home phone ( ) -

Cell phone ( ) -

Email address(es)

Social Security #

Employer

# Dental Insurance

Primary policy holder’s full name

Birth date

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

Birth date

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

# Medical Insurance

Policy holder’s full name / ID# Insurance Company

## 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, please mark yes, no, or don’t know/understand (dk/u). Do NOT make one line through all the boxes, they MUST be individually marked.***

# Medical History

## Now or in the past, have you had:

**Yes No DK/U**

Birth defects or hereditary problems? Bone fractures or major injuries?

Any injuries to face, head, neck? Arthritis or joint problems?

Endocrine or thyroid problems? Diabetes or low sugar?

Kidney problems?

Cancer, tumor, radiation treatment or chemotherapy? Stomach ulcer, hyperacidity, acid reflux

Immune system problems? History of osteoporosis?

Gonorrhea, syphilis, herpes, sexually transmitted diseases? AIDS or HIV positive?

Hepatitis A, Hepatitis B or Hepatitis C?

Hepatitis, jaundice, or other liver problems? Polio, mononucleosis, tuberculosis, pneumonia? Seizures, fainting spells, neurologic problems? Mental health disturbance or depression?

Vision, hearing, or speech problems?

History of eating disorder (anorexia, bulimia)? High or low blood pressure?

Excessive bleeding or bruising, anemia?

Chest pain, shortness of breath, tire easily, swollen ankles? Heart defects, heart murmur, rheumatic heart disease?

Angina, arteriosclerosis, stroke or heart attack? Skin disorder (other than common acne)?

Do you eat a well-balanced diet? Frequent headaches or migraines?

Frequent ear infections, colds, throat infections? Asthma, sinus problems, hay fever?

Tonsil or adenoid condition?

Do you frequently breathe through your mouth?

## Have you had allergies or reactions to any of the following?

**Yes No DK/U**

Local anesthetics (Novocain, lidocaine, xylocaine) Latex (gloves, balloons)

Aspirin

Metals (jewelry, clothing snaps) Penicillin

Other antibiotics Ibuprofen (Motrin, Advil) Acrylics

Plant pollens Animals Foods

Other substances

# Dental History

## Now or in the past, have you had:

Yes No DK/U

Permanent or extra (supernumerary) teeth removed? Supernumerary (extra) or congenitally missing teeth? Chipped or injured primary or permanent teeth?

Any sensitive or sore teeth?

Bleeding gums, bad taste or mouth odor? Jaw fractures, cysts, infections?

Any teeth treated with root canals or pulpotomies? “Gum boils,” frequent canker sores or cold sores? History of speech problems or speech therapy?

Difficulty breathing through nose? Food impaction between the teeth?

Mouth breathing habit or snoring at night?

Frequent oral habits (sucking finger, chewing pen, etc.)? Teeth causing irritation to lip, cheek or gums?

Abnormal swallowing (tongue thrust)? Tooth grinding or clenching?

Clicking, locking in jaw joints?

Soreness in jaw muscles or face muscles?

Ringing in ears, difficulty in chewing or opening jaw?

Have you ever been treated for “TMJ” or “TMD” problems? Any broken or missing fillings

Any serious trouble associated with previous dental treatment? Have you ever been diagnosed with gum disease or pyorrhea?

Have you ever had an orthodontic consultation or treatment before now?

# Patient Health Information

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

Medication Medication Medication

Taken for Taken for Taken for

Have you ever taken any medications to strengthen your bones? Please describe.

Do you take antibiotic pre-medication before any dental procedures? Do you or have you ever had a substance abuse problem? Do you chew or smoke tobacco? Have you noticed any changes in your face or jaws? Any other physical problems?

How often do you brush?

How often do you floss?

Women: Are you pregnant? Yes No Are you trying to become pregnant? Yes No

# Family Medical History

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

Bleeding disorders Arthritis Unusual dental problems

Diabetes Severe allergies Jaw size imbalance

Other family medical conditions?

# 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

Doctor Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Medical History Updates or Changes

Changes

Signature Dental Staff Signature

Date Date

Changes

Signature Dental Staff Signature

Date Date

Changes

Signature Dental Staff Signature

Date Date

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