|  |  |  |
| --- | --- | --- |
| \\server\users\CRRFront2\Desktop\AAO-logo-M-clr-s.jpg | **Medical Dental History Form****for Adult Patients**  |  CONFIDENTIAL Patient #:\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**PATIENT**

|  |  |  |
| --- | --- | --- |
|  |  |  Appointment Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  Prefers to be called \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_ M F  |
| Marital Status: Single Married Divorced Separated |  |
| Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Home Phone ( )\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ |  Cell Phone ( )\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ |  Work Phone ( )\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ |
| Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Employed By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Name and ages of children in family \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Family members in our orthodontic practice \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |

**FINANCIAL RESPONSIBILITY**

|  |
| --- |
| Name of person(s) responsible for this account? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address *(if different than above)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Home Phone ( )\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ |  Cell Phone ( )\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ | Work Phone ( )\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ |

**DENTAL INSURANCE**

|  |
| --- |
| Do you have Dental Insurance? Yes No If yes, is there an orthodontic benefit? Yes No Don’t Know |
| **\*\*Please provide your insurance information if not given prior to your appointment.** |
|  |

**DENTIST**

|  |  |
| --- | --- |
| Patient’s Dentist Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Date last seen \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Name of other dentists/dental specialists seen \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**GENERAL INFORMATION**

|  |
| --- |
| What is your main concern today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How often do you brush?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often do you floss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Who referred you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Who suggested that you might need orthodontic treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Describe any previous orthodontic treatment or consultations. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**PATIENT HEALTH INFORMATION**

|  |
| --- |
| List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements |
| that you take. |
| Medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Taken for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Taken for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Taken for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 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 chew or smoke tobacco? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Is there anything else we need to know about you that would help us make you feel more comfortable during your time here in the office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Adult form 2nd page**

**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).*

|  |
| --- |
|  |
| **MEDICAL HISTORY** | **DENTAL HISTORY** |
| **Now or in the past, have you had :** | **Now or in the past, have you had:** |
| **Yes No DK** | **Yes no DK** |
| **⃝ ⃝ ⃝**  | If female, are you pregnant? | **⃝ ⃝ ⃝**  | Bleeding gums? |
| **⃝ ⃝ ⃝**  | Any injuries to face, head, neck? | **⃝ ⃝ ⃝**  | Food impaction between teeth? |
| **⃝ ⃝ ⃝**  | Arthritis or joint problems? | **⃝ ⃝ ⃝**  | Permanent or extra (supernumerary) teeth removed? |
| **⃝ ⃝ ⃝**  | Cancer, tumor, radiation treatment or chemotherapy? | **⃝ ⃝ ⃝**  | Supernumerary (extra) or congenitally missing teeth? |
| **⃝ ⃝ ⃝**  | Diabetes or low sugar? | **⃝ ⃝ ⃝**  | Chipped or injured primary or permanent teeth? |
| **⃝ ⃝ ⃝**  | History of osteoporosis? | **⃝ ⃝ ⃝**  | Any sensitive or sore teeth? |
| **⃝ ⃝ ⃝**  | Birth defects or hereditary Problems? | **⃝ ⃝ ⃝**  | Any broken or missing fillings? |
| **⃝ ⃝ ⃝**  | Frequent headaches or migraines? | **⃝ ⃝ ⃝**  | Jaw fractures, cysts, infections? |
| **⃝ ⃝ ⃝**  | High or low blood pressure? | **⃝ ⃝ ⃝**  | Any teeth treated with root canals or pulpotomies? |
| **⃝ ⃝ ⃝** | Excessive bleeding or bruising, anemia? | **⃝ ⃝ ⃝**  | History of speech problem or speech therapy? |
| **⃝ ⃝ ⃝** | Heart defects, heart murmur, rheumatic heart disease? | **⃝ ⃝ ⃝**  | Finger sucking or thumb sucking? |
| **⃝ ⃝ ⃝**  | Angina, Arteriosclerosis, stroke or heart attack? | **⃝ ⃝ ⃝**  | Tooth grinding or clenching? |
| **⃝ ⃝ ⃝**  | Stomach ulcer, hyperacidity, acid reflux? | **⃝ ⃝ ⃝**  | Ringing in ears, difficulty in chewing or opening jaw? |
| **⃝ ⃝ ⃝** | Chest pain, shortness of breath, tire easily, swollen ankles? | **⃝ ⃝ ⃝**  | Clicking, locking in jaw joints? |
| **⃝ ⃝ ⃝** | Have you ever taken intravenous bisphosphonates such  | **⃝ ⃝ ⃝**  | Soreness in jaw muscles or face muscles? |
|  | as Zometa (Zolendromic acid), Aredia (pamidronate) or | **⃝ ⃝ ⃝** | Have you ever been treated for “TMJ” or “TMD” |
|  | Didronel (etidronate) for bone disorders or cancer? |  | Problems? |
| **⃝ ⃝ ⃝** | Have you ever taken oral bisphosphonates such as | **⃝ ⃝ ⃝** | Have you ever seen a periodontist or gum specialist? |
|  | 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** |  |
| **⃝ ⃝ ⃝**  | **Latex (gloves, balloons)** |  |
| **⃝ ⃝ ⃝**  | Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| **⃝ ⃝ ⃝**  | Metals (jewelry, clothing snaps) |  |  |
| **⃝ ⃝ ⃝**  | Acrylics |  |  |
| **⃝ ⃝ ⃝**  | Foods Type ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |  |  |  |
|  |  |  |  |

**RELEASE AND WAIVER**

*I authorize release of any information regarding my orthodontic treatment to my dental and/or medical Insurance company and to send letters or communicate verbally with my dentist and /or dental specialists. I hereby give my permission for the use of orthodontic records, including photographs, made in the process of examinations, treatment, and retention for purposes of professional consultations, research or education.*

**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**