CONFIDENTIAL MEDICAL/DENTAL HISTORY
FOR PATIENTS OVER 18

WELCOME!

First Name:_________________________ **MI:** ___ **Last Name:**________________________________

I prefer to be called**:**___________________________ Gender: M F

Birth date (mm/dd/yyyy):______________________ Age: __________

Street Address: ____ **Apt/Unit #:** ___________

City: _______________________________ **State:** _________ **Zip Code:** ___________________

Home Phone #: ________________ Cell Phone #: _______________ E-mail Address: ___________________________

Employer/Occupation: _______________________________________ Business Phone #: _____________________

□Single □Widowed □Divorced □Married Spouse's Name: ____

Spouse's Employer/Occupation: _______________________________ Business Phone #: _____________________

General Dentist: ____________________________________ Date of Last Exam: ___________________________

Whom may we thank for referring you to our office? ____

Other family members seen by us: ______________________________

PERSON RESPONSIBLE FOR ACCOUNT:____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE INFORMATION

Policy Holder's Name: ________________________
Date of Birth: _________________________________
Social Sec. #:_________________________________
Relationship to Patient: ________________________
Employer: ____________________________________
Work Phone: __________________________________
Insurance Company: ___________________________
ID #: _________________ Group #: _____________
Address: ______________________________________
Phone # on Ins. Card: __________________________

SECONDARY DENTAL INSURANCE INFORMATION

Policy Holder's Name: ________________________
Date of Birth: _________________________________
Social Sec. #:_________________________________
Relationship to Patient: ________________________
Employer: ____________________________________
Work Phone: __________________________________
Insurance Company: ___________________________
ID #: _________________ Group #: _____________
Address: ______________________________________
Phone # on Ins. Card: __________________________

MEDICAL HISTORY

Your answers are for office records only and are confidential. A thorough medical and dental history is essential to a complete orthodontic evaluation.

1. Have you ever had or currently have any of the following? Please check those that apply:

□ HIV/AIDS
□ Allergies_____________________
____
____
□ Anemia
□ Arthritis
□ Artificial Joints
□ Asthma
□ Blood Disease
□ Brain Injury
□ Bone Disorder
□ Chest Pain, Shortness of Breath
□ Chemotherapy
□ Cancer
□ Diabetes, or low blood sugar
□ Dizziness
□ Earaches
□ Emotional Problems
□ Epilepsy
□ Excessive Bleeding
□ Fainting/Dizziness
□ Glaucoma
□ Hay Fever
□ Frequent Headaches or Migranes
□ Head Injuries
□ Heart Murmur
□ Hepatitis, or liver problem
□ High or Low Blood Pressure
□ Jaundice
□ Kidney Disease
□ Liver Disease
□ Mental Disorders
□ Mitral Valve Prolapse
□ Nervous Disorders
□ Pacemaker
□ Radiation Treatment
□ Removal of Adenoids or Tonsils
□ Respiratory Problems
□ Rheumatic Fever
□ Rheumatism
□ Sinus Problems
□ Speech Problems
□ Stomach Problems
□ Seizures, Neurologic Problems
□ Stroke
□ Thyroid Problems
□ Tuberculosis
□ Tumors
□ Ulcers
□ Vision, hearing problems
□ Venereal Disease
□ Other: ______________
____

For Women: Are you taking birth control pills? □Yes □No
Are you pregnant? □Unsure □No □Yes Week #:______ Are you nursing? □Yes □No

2. Have you been admitted to a hospital or needed emergency care during the past two years? □Yes □No
If yes, please explain ____
3. Have you ever taken Bisphosphonate medication (e.g. Fosamax, Actonel, Boniva, Skelid or Didronel for bone disorder)?
□Yes □No If yes, what medication and length of time on the medication ________________________________
4. Are you now under the care of a physician? □Yes □No
Name of Physician: Phone:
5. Do you currently have (or ever had) a substance abuse problem? □Yes □No
6. Do you chew or smoke tobacco? □Yes □No
7. List any medication, nutritional supplements, herbal medications or non-prescription medicines that you currently take:
Medication ______________________________ Taken for ______________________________
Medication ______________________________ Taken for ______________________________
Medication ______________________________ Taken for ______________________________
8. Are there any medical conditions we have not listed and you feel we should be aware of? □Yes □No
If yes, please explain ____

DENTAL HISTORY

1. What concerns you most about your teeth? ____
2. Do you have any current dental problems? ____
3. Have you ever had orthodontic treatment? □Yes □No
If yes, please explain: ____
4. Has anyone in your family received orthodontic treatment? □Yes □No
If yes, who? ____
5. Do you feel nervous about having dental treatment? □Yes □No
If yes, what is your biggest concern? ____
6. Have you ever had an upsetting dental experience? □Yes □No
If yes, please describe: ____

Please answer the following:

- Are you presently in any dental pain? □Yes □No
- Are your teeth sensitive? □Yes □No
- Do your gums bleed or hurt? □Yes □No
- Allergy to Latex? □Yes □No
- Have you noticed any loose teeth or changes in your bite? □Yes □No
- Do you clench or grind your teeth? □Yes □No
- Do you have a clicking or popping in your jaw? □Yes □No

I have read the above questions and understand them. To the best of my knowledge, all of the preceding answers and information are true and correct. I will not hold the orthodontist and any member of the staff responsible for any errors or omissions that I have made in the completion of this form. I will notify the orthodontist of any changes in my medical and dental health and insurance information if applicable.

____ Date: _______________________

Signature of patient, parent, or guardian