



ADULT MEDICAL AND DENTAL HISTORY

PATIENT INFORMATION:

TODAY'S DATE: ___ / ___ / ___

PATIENT: _____

First MI Last

STREET ADDRESS: _____

AGE: _____

CITY: _____ STATE: _____ ZIP: _____

DOB: ___ / ___ / ___

PREFERRED PHONE #: (_____) _____ (Home / Work / Cell)

MALE:

SECONDARY PHONE #: (_____) _____ (Home / Work / Cell)

FEMALE:

EMAIL: _____

EMERGENCY CONTACT NAME: _____ PHONE #: (_____) _____

EMERGENCY CONTACT RELATION: _____

MAIN CONCERNS:

WHY ARE YOU SEEKING ORTHODONTIC TREATMENT (MAIN CONCERN)? _____

INTERESTED IN (please circle): BRACES CLEAR BRACES INVISALIGN OTHER

HOW DID YOU HEAR ABOUT US? _____

FINANCIAL AND INSURANCE INFORMATION:

PRIMARY DENTAL INSURANCE	
INSURANCE NAME	
INSURANCE PHONE #	
SUBSCRIBER NAME	
SUBSCRIBER ID	
SUBSCRIBER SSN	
SUBSCRIBER DOB	___ / ___ / _____
GROUP PLAN #	
ORTHO COVERAGE?	YES / NO / UNSURE

SECONDARY DENTAL INSURANCE	
INSURANCE NAME	
INSURANCE PHONE #	
SUBSCRIBER NAME	
SUBSCRIBER ID	
SUBSCRIBER SSN	
SUBSCRIBER DOB	___ / ___ / _____
GROUP PLAN #	
ORTHO COVERAGE?	YES / NO / UNSURE

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

Patient Signature: _____ Date: ___ / ___ / _____

(Please continue onto the next page)

DENTAL HISTORY:

DENTIST NAME: _____ LOCATION: _____ LAST VISIT: ____ / ____
City State MO / YEAR
REASON FOR LAST VISIT: _____

HAVE YOU EVER HAD AN ORTHODONTIC EXAM AND EVALUATION? YES / NO

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Clenching/Grinding of teeth?	Y	N
Thumb/Finger sucking habit?	Y	N
Tongue thrust habit?	Y	N
Lip or cheek biting habit?	Y	N
Mouth breathing or trouble breathing through nose?	Y	N
Unfavorable reaction or traumatic dental visit?	Y	N
Unusual change to face or bite?	Y	N
Snoring or sleep apnea?	Y	N

Injury to face, mouth, teeth or chin?	Y	N
Speech problems?	Y	N
Jaw joint problems or soreness in TMJ?	Y	N
Chipped teeth?	Y	N
Late erupting or missing adult teeth?	Y	N
Gum disease?	Y	N
Previous orthodontic treatment?	Y	N

MEDICAL HISTORY:

PHYSICIAN NAME: _____ LOCATION: _____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? YES / NO

IF YES, LIST **MEDICATION AND CONDITION:** _____

LIST ALL **ALLERGIES** (MEDICATION/FOOD/ETC.): _____

DO YOU PRE-MEDICATE WITH ANTIBIOTICS FOR DENTAL PROCEDURES? YES / NO

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Allergy to latex?	Y	N
Allergy to metal?	Y	N
Allergy to local anesthetics (lidocaine, novacaine etc)?	Y	N
Cancer, tumor, radiation treatment, or chemotherapy?	Y	N
Skin problems?	Y	N
Neurological problems, migraines, seizures, epilepsy?	Y	N
Eyes / Ears / Nose / Throat problems?	Y	N
Tonsils/adenoids removed?	Y	N
Genetic or hereditary problems?	Y	N
Endocrine problems, diabetes, thyroid problems?	Y	N

Respiratory problems, asthma, TB?	Y	N
Cardiovascular problems, heart problems, murmurs, blood pressure, heart defect?	Y	N
Gastrointestinal / liver problems, hepatitis?	Y	N
Kidney problems?	Y	N
Musculoskeletal problems, arthritis, injuries?	Y	N
Immunologic problems, influenza, HIV/AIDS?	Y	N
Herpes, syphilis, gonorrhea?	Y	N
Cleft lip/palate?	Y	N
Eating disorders, anorexia, bulimia?	Y	N
Mental health problems, depression?	Y	N

IF "YES" TO ABOVE QUESTIONS, PLEASE SPECIFY: _____

DO YOU HAVE ANY MEDICAL PROBLEM NOT LISTED ABOVE? _____

SIGNATURE:

I have read the above questions and understand them. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of the form. I will notify my orthodontist of any changes to my medical or dental health.

Patient Signature: _____ **Date:** ____/____/____