American Association of Orthodontists

CONFIDENTIAL

Medical Dental History Form for Adult Patients

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 (____) ____- ____

E-mail address(es) _____

Occupation _____ Employer _____

CLOSEST RELATIVE

Spouse or closest relatives name(s) _____

Title ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss. ☐ Dr. ☐ Other _____ Relationship to patient _____

Address *(if different than patient address)* _____

Home phone (____) ____- ____ 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 from page 1*) _____ City, State, Zip_____

Home phone (____) ____ - ____ Cell phone (____) ____ - ____ E-mail address(es)_____

Social Security # ___- __ - ____ Employer:_____

Who will be responsible for bringing the patient to orthodontic appointments? _____

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

MEDICAL INSURANCE

Policy holder's full name _____

Insurance company _____

Your answers are for office records only, and are confidential. A thorough medial 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 Stomach ulcer, hyperacidity, acid reflux?
- ☐yes ☐no ☐dk/u Immune system problems?
- ☐yes ☐no ☐dk/u History of osteoporosis?
- ☐yes ☐no ☐dk/u Gonorrhea, syphilis, herpes, sexually transmitted diseases?
- ☐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, shortness 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 r adenoid condition?
- ☐yes ☐no ☐dk/u Do you frequently breathe through your mouth?

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

- ☐yes ☐no ☐dk/u Local anesthetics (novocaine, 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 Metals (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 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 Bleeding gums, bad taste or mouth odor?
- ☐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 Food impaction between the teeth?
- ☐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 pen, etc.)?
- ☐yes ☐no ☐dk/u Teeth causing irritation to lip, cheek or gums?
- ☐yes ☐no ☐dk/u Abnormal swallowing (tongue thrust)?
- ☐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 Ringing in ears, difficulty in chewing or opening jaw?
- ☐yes ☐no ☐dk/u Have you ever 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 Have 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

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 _____

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

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 _____

Diabetes _____

Arthritis _____

Severe allergies _____

Unusual dental problems _____

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 _____ Date _____

MEDICAL HISTORY UPDATES OR CHANGES

Changes _____
Patient Signature _____ Date _____
Dental Staff Signature _____ Date _____

Changes _____
Patient Signature _____ Date _____
Dental Staff Signature _____ Date _____

Changes _____
Patient Signature _____ Date _____
Dental Staff Signature _____ Date _____

SUBMIT