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_____