## ADULT MEDICAL DENTAL HISTORY FORM

**DATE**_____

| YOUR NAME (title, First, Middle, Last) | AGE | I PREFER TO BE CALLED |
|---|---|---|
| | | |

| BIRTH DATE | MARITAL STATUS | OCCUPATION & EMPLOYER |
|---|---|---|
| | ☐SINGLE ☐MARRIED ☐SEPARATED ☐DIVORCED ☐WIDOWED | |

| HOME ADDRESS (street, city, state, zip code) | SOCIAL SECURITY NUMBER | Gender ☐MALE ☐FEMALE ☐OTHER |
|---|---|---|
| | | |

| EMAIL ADDRESS - we promise to keep this private and not send you spam | HOME PHONE | CELL PHONE | WORK PHONE |
|---|---|---|---|
| | | | |

| SPOUSE OR CLOSEST RELATIVE'S NAME AND TITLE | RELATIONSHIP TO PATIENT | PHONE NUMBER |
|---|---|---|
| | | |

| HOW DID YOU FIND US? (Which friend, website, dentist?) | DENTIST (Do you need a new one? We can help) | DATE LAST SEEN (approximately) |
|---|---|---|
| | | |

## DENTAL INFORMATION

HAVE YOU HAD PREVIOUS ORTHODONTIC TREATMENT? ☐NO ☐YES If yes, please explain below.

.....

HAVE WE TREATED ANYONE ELSE IN YOUR FAMILY? ☐NO ☐YES Who?.....

HAVE THERE BEEN ANY INJURIES TO THE JAWS OR TEETH? ☐NO ☐YES In a nut shell.....

ANY CLICKING, POPPING OR DISCOMFORT OF THE JAW OR JAW JOINT ☐NO ☐YES Please elaborate.....

DO YOUR GUMS EVER BLEED? ☐NO ☐YES Don't lie.....

HAVE YOU EVER BEEN TREATED FOR ANY GUM PROBLEMS ☐NO ☐YES Spill the beans.....

**WHY ARE YOU SEEKING AN ORTHODONTIC CONSULTATION?** (Please explain below)

.....

**DID YOU HAVE ANY TYPE OF TREATMENT YOU HAVE HEARD ABOUT THAT YOU ARE PARTICULARLY INTERESTED IN?** (Please explain below)

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## MEDICAL INFORMATION

YOUR PHYSICIAN'S NAME /LOCATION:.....

ARE YOU IN GOOD HEALTH? ☐NO ☐YES IF NO, PLEASE EXPLAIN.....

ARE YOU CURRENTLY RECEIVING MEDICAL TREATMENT? ☐NO ☐YES EXPLAIN.....

DO YOU HAVE A HISTORY OF ANY MAJOR ILLNESSES ☐NO ☐YES EXPLAIN.....

ARE YOU CURRENTLY TAKING ANY DRUGS OR MEDICATION? ☐NO ☐YES WHAT for WHAT?.....

ANY ALLERGIES OR SENSITIVITY TO DRUGS, METALS OR LATEX? ☐NO ☐YES EXPLAIN.....What about Nickel? .....

### CHECK ANY OF THE FOLLOWING FOR WHICH YOU HAVE BEEN TREATED (please explain below)

| | | | | | |
|---|---|---|---|---|---|
| PROLONGED BLEEDING | ☐ | ANEMIA | ☐ | TUBERCULOSIS | ☐ |
| LIVER PROBLEMS | ☐ | DIABETES | ☐ | HEPATITIS | ☐ |
| PNEUMONIA | ☐ | ASTHMA | ☐ | HIV/AIDS | ☐ |
| LOW BONE DENSITY | ☐ | EPILEPSY | ☐ | BONE DISORDER | ☐ |
| ENDOCRINE PROBLEMS | ☐ | RHEUMATIC FEVER | ☐ | LATEX ALLERGIES | ☐ |
| NERVOUS DISORDER | ☐ | HEART TROUBLE/ MUMUR | ☐ | OTHER PLEASE ELABORATE BELOW | ☐ |

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****Friendly Reminder****

*DENTAL INSURANCE IS A CONTRACT BETWEEN YOUR COMPANY AND THE INSURANCE COMPANY. WE WILL HELP YOU ANY WAY WE CAN, BUT ULTIMATELY YOU ARE RESPONSIBLE FOR SERVICES RENDERED BY THIS OFFICE.*