ORTHODONTIC

Medical and Dental History for Adult Patients

Patient's Last Name: ____________________________ First Name: __________________________________ Middle Initial: ________ Title: ____________

Preferred Name: ____ Date of Birth: _________/________/__________ Age: __________ Gender: M / F

Address: ____ City: _______________________________ State: ____ Zip: _____________

Phone #: (Cell) ________________________________ (Work) ____ (Home) ______________________________

Social Security #: ____

E-mail address: ____ Any family members treated here? _____________________________________

Employer: ____ Job Title: ____

Who is financially responsible for this account? Last name: ________________________________ First: _____________________________ MI: __________

Address (if different): ____

City: ____ State: _______ Zip: __________________ Phone #: ________________________________

Employer: ____ Job Title: ____

Insurance Information: Primary policy holder's: Last Name: __________________________________ First: _________________________ Middle initial: ___

Address (if different from patient): ____

City: ____ State: _______ Zip: _______________ Phone #: ______________________________

SSN#: ___________-__________-_____________ Date of Birth: _________/_________/__________ Employed By: __________________________________

Dental Insurance Company: ____ Group #: _______________________________

Secondary policy holder's name: Last Name: ____ First: __________________________________ Middle initial: ___

Address (if different from patient): ____

City: ____ State: _______ Zip: _______________ Phone #: ______________________________

SSN#: ___________-__________-_____________ Date of Birth: _________/_________/__________ Employed By: __________________________________

Dental Insurance Company: ____ Group #: _______________________________

How did you hear about our office? ____

General dentist's name: ____ City: ____ State: _________

Date of patient's last cleaning: _____________/______________/_____________

Physician's name: ____ City: ____ State: _________

For the following questions please mark yes (Y) or no (N). These answers are for office records only and are confidential. A thorough medical history is necessary for a proper orthodontic evaluation.

MEDICAL HISTORY Now or in the past has the patient had:

Y	N	Learning disabilities or need extra help with instructions?
Y	N	ADD or ADHD?
Y	N	Birth defects or hereditary problems?
Y	N	Are you adopted?
Y	N	Rheumatoid or arthritic conditions?
Y	N	Endocrine or thyroid problems?
Y	N	Diabetes?
Y	N	Cancer, tumor, radiation treatment, or chemotherapy?
Y	N	Acid reflux?
Y	N	Tuberculosis, polio, mononucleosis, or pneumonia?
Y	N	Problems of the immune system?
Y	N	HIV or AIDS?
Y	N	Hepatitis, jaundice, or liver problems?
Y	N	Seizures, epilepsy, fainting spells, or neurological problems?
Y	N	Mental health disturbance or depression?
Y	N	Vision, hearing, taste, or speech difficulties?
Y	N	History of eating disorder, anorexia, or bulimia?
Y	N	Excessive bleeding or bruising tendency, anemia, or bleeding disorder?
Y	N	High or low blood pressure?
Y	N	Cardiovascular problems such as shortness of breath, angina, heart attack?
Y	N	Heart murmur, rheumatic fever, inborn heart defects, artificial heart valves?
Y	N	Allergies or asthma?
Y	N	Osteoporosis?
Y	N	Ear, nose, throat, tonsil, or adenoid conditions?

Allergies or reactions to any of the following:

Y	N	Aspirin or Ibuprofen?
Y	N	Penicillin or other antibiotics?
Y	N	Codeine or other narcotics?
Y	N	Metals?
Y	N	Latex?
Y	N	Other Substances: ______________________________

Please list any medications, nutrient supplements, herbal medications, or non-prescription medicine the patient is currently taking:

____

Y	N	Do you currently have or ever had a substance abuse problem?
Y	N	Please list any operations or hospitalizations: ______________________________
Y	N	Being treated by another healthcare professional? For ______________________________

For Women Only:

Y	N	Are you pregnant?
Y	N	Are you anticipating becoming pregnant?

Dental History Now or in the past, has the patient had:

Y	N	Extra or supernumerary teeth?
Y	N	Congenitally missing teeth or any permanent teeth removed?
Y	N	Early loss of baby teeth due to decay or trauma?
Y	N	Trauma or injury to baby or permanent teeth?
Y	N	Jaw fractures, cysts, or mouth infections?
Y	N	Periodontal or gum problems?
Y	N	Thumb or finger sucking habit? Until what age? ________________
Y	N	Tongue thrusting?
Y	N	History of speech problems?
Y	N	Mouth breathing habit?
Y	N	Tooth grinding, jaw clenching, clicking, or locking, or other problems of the TMJ?
Y	N	Any pain in jaw or face, ringing in the ears, or severe headaches?
Y	N	Frequent canker sores or cold sores?
Y	N	Any relative with similar tooth or jaw relationships?
Y	N	Any relative with jaw size imbalance?
Y	N	Ever had a prior orthodontic examination or treatment?
Y	N	Ever been or currently treated for periodontal disease?

I have read and understand the above questions. I will not hold Bivens Orthodontics responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform the practice.

Signed: ____ **Date:** ______________________
(Patient/guardian)

Signed: ____ **Date:** ______________________
(Dental Staff member)

For Office Use Only	
Entered:	
Alert:	