MEDICAL DENTAL HISTORY FORM (Adult)

Date _____

PATIENT / CONTACT INFORMATION

First name _____ Last name _____ Middle initial_____

I prefer to be called _____ Title ___Mr. ___Mrs. ___Miss ___Dr. ___ Other (_____)

Marital Status __Single __Married __Separated __Divorced __Widowed Gender ___ Male ___ Female ___ Other (_____)

Birth date _____ Age _____ Driver License _____ Social Security # _____

Home address _____ City, State, Zip code _____

Primary phone (__ Home __Cell __Work) _____ Other phone (__ Home __Cell __Work) _____

E-mail address(es) _____

Occupation _____ Employer _____ City, State _____

In case of emergency, who should we contact? Name _____ Relation _____

Phone _____ E-mail address _____

FINANCIALLY RESPONSIBLE PERSON

___ Same as above ___ Different than above (complete information below):

First name _____ Last name _____ Middle initial_____

Home address _____ City, State, Zip code _____

Primary phone (__ Home __Cell __Work) _____ Other phone (__ Home __Cell __Work) _____

E-mail address_____ Driver License _____ Social Security # _____

DENTAL INSURANCE

Member's full name _____ Birth date _____

Relationship to patient _____ Social Security Number _____

Employer _____ Address _____

Insurance company_____ Group # _____ ID# _____

Does this policy have orthodontic benefits? ___ Yes ___ No ___ Don't Know

SECONDARY DENTAL INSURANCE

Member's full name _____ Birth date _____

Relationship to patient _____ Social Security Number _____

Employer _____ Address _____

Insurance company_____ Group # _____ ID# _____

Does this policy have orthodontic benefits? ___ Yes ___ No ___ Don't Know

Name _____ Date _____

PHYSICIAN

Physician_____ Phone _____ City, State_____

Are you currently under the care of a physician? __ Y / __ N (Reason _____)

Other physicians / health care providers being seen now:

Name _____City, State _____ Reason _____

Name _____City, State _____ Reason _____

Name _____City, State _____ Reason _____

DENTIST

Dentist _____ Dentist Phone _____

Address, City, State _____ Last Cleaning / Examination _____

Other dental specialists being seen: Name _____ City, State _____

Reason_____

GENERAL INFORMATION

What concerns you about your teeth? _____

How do you feel about orthodontic treatment? _____Wearing braces? _____

Who suggested that you might need orthodontic treatment? _____

Whom may we thank for referring you to our office?_____

Have you had any previous orthodontic treatment? __Yes __No (When? _____ By whom? _____)

Have you had any previous orthodontic consultations? __Yes __No (When? _____ By whom? _____)

Have any other family members been treated in this office? Please name them _____

Do you have any oral habits? __ Thumb sucking __ Chew gum __ Bite fingernails __ Bite lower lip __ Chews ice, pens, straws, other _____

Do you chew / smoke tobacco or vape? __Yes __No (Explain & how often? _____)

Are you actively playing any sports? __Yes __No (Explain _____)

Do you think any of your work or leisure activities affect your teeth or jaw? __Yes __No (Explain _____)

PATIENT HEALTH INFORMATION

Do you take antibiotic pre-medication before any dental procedures? __Yes __No (Reason _____)

List any medication, or non-prescription medicines, including fluoride supplements you take and for what reason:

_____

_____

_____

Any serious medical condition, illness, hospitalization, or physical problems? _____

_____

_____

_____

Do you have any known allergies? __Yes __No (check all that apply)

__ Latex (gloves, balloons), __ Metals (nickel, jewelry, other), __ Penicillin, __ Amoxicillin, __ Aspirin, __ Ibuprofen (Motrin, Advil), __ Codiene / Narcotics,

__ Local anesthetics (novocaine, lidocaine, xylocaine), __ Acrylics, __ Other (_____)

Female patients: Are you pregnant? __Yes __No (Due date _____) Are you trying to become pregnant? __Yes __No

Name _____ Date _____

DENTAL HISTORY

Please mark Yes, No, or Unknown for each question below. NOW OR IN THE PAST, HAVE YOU EXPERIENCED ….

Y	N	?	
☐	☐	☐	Supernumerary (extra) teeth?
☐	☐	☐	Congenitally (at birth) missing teeth?
☐	☐	☐	Permanent (adult) teeth removed?
☐	☐	☐	Any dental implants or fixed bridges?
☐	☐	☐	Chipped or injured primary or permanent teeth?
☐	☐	☐	Any sensitive or sore teeth?
☐	☐	☐	Bleeding gums, bad taste or mouth odor?
☐	☐	☐	Diagnosed with gum disease?
☐	☐	☐	History of speech problems or speech therapy?
☐	☐	☐	Difficulty breathing through nose
☐	☐	☐	Mouth breathing habit or snoring at night?
☐	☐	☐	Teeth grinding or clenching?

Y	N	?	
☐	☐	☐	Clicking or popping of the jaw joints (the TMJ)
☐	☐	☐	Locking of jaws (can't open or can't close jaws)
☐	☐	☐	Pain associated with opening/closing jaws
☐	☐	☐	Any treatment for TMJ or TMD problems?
☐	☐	☐	Frequent canker sores or cold sores?
☐	☐	☐	Jaw fractures, cysts, infections?
☐	☐	☐	Injuries to the face or mouth?
☐	☐	☐	Injuires to the teeth?
☐	☐	☐	Excessive cheek biting?
☐	☐	☐	Excessive food trapping between teeth?
☐	☐	☐	Difficulty brushing or flossing?
☐	☐	☐	Difficulty biting, tearing, or chewing food?

MEDICAL HISTORY

Please mark Yes, No, or Unknown for each question below. NOW OR IN THE PAST, HAVE YOU EXPERIENCED ….

Y	N	?	
☐	☐	☐	Vision or hearing problems?
☐	☐	☐	Heart murmur?
☐	☐	☐	Heart defects or other Heart problems?
☐	☐	☐	Heart surgery, or artifical valve placement?
☐	☐	☐	Chest pain, heart attack, or stroke?
☐	☐	☐	High blood pressure?
☐	☐	☐	Excessive bleeding / bruising, or other blood disorders?
☐	☐	☐	Anemia?
☐	☐	☐	Cancer, Radiation or Chemotherapy?
☐	☐	☐	Hypothyroidism?
☐	☐	☐	Hyperthyroidism?
☐	☐	☐	Diabetes?
☐	☐	☐	Other endocrine problems?
☐	☐	☐	Hereditary or developmental conditions?
☐	☐	☐	Immune system problems?
☐	☐	☐	Frequent ear infections, colds, throat infections?
☐	☐	☐	Asthma?
			Asthma triggers: __allergies, __smoke/pollution, __weather, __respiratory infections, __physical exercise, __emotional stress
☐	☐	☐	Sinus problems, hay fever, seasonal allergies?
☐	☐	☐	Enlarged tonsils or adenoids?
☐	☐	☐	Lung problems or difficulty breathing?
☐	☐	☐	Emphysema, bronchitis?

Y	N	?	
☐	☐	☐	Polio, mononucleosis, tuberculosis?
☐	☐	☐	Arthritis or joint problems?
☐	☐	☐	Skin disorder (other than common acne)?
☐	☐	☐	Osteoporosis or other bone disorders?
☐	☐	☐	Intravenous bisphosphonates like Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate)?
☐	☐	☐	Oral bisphosphonates like Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate)?
☐	☐	☐	Nervous system problems?
☐	☐	☐	Seizures or fainting spells?
☐	☐	☐	Frequent headaches or migraines
☐	☐	☐	Fibromyalgia?
☐	☐	☐	Emotional, sensory or developmental issues?
☐	☐	☐	Mental health problems, anxiety or depression?
☐	☐	☐	Eating disorder (anorexia, bulimia)?
☐	☐	☐	Drug or alcohol abuse?
☐	☐	☐	Fever blisters or Herpes simplex virus?
☐	☐	☐	AIDS or HIV positive?
☐	☐	☐	Gonorrhea, syphilis, or other STD?
☐	☐	☐	Hepatitis, jaundice, or other liver problems?
☐	☐	☐	Kidney problems?
☐	☐	☐	Stomach ulcer, hyperacidity, acid reflux?

RELEASE AND WAIVER

I have read the above questions and understand them. I will not hold Dr. Patrick Lee or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I will notify Dr. Patrick Lee of any changes in my medical or dental health. In addition, I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Patient Signature _____ Date _____

Doctor Signature _____ Date _____

MEDICAL HISTORY UPDATES (Please fill out a new form if changes are significant)

Changes since last time? ___Yes ___No (Explain _____)

Signature _____ Date _____ Witness _____

Changes since last time? ___Yes ___No (Explain _____)

Signature _____ Date _____ Witness _____

Changes since last time? ___Yes ___No (Explain _____)

Signature _____ Date _____ Witness _____