Members American Association of Orthodontists

Medical Dental History Form
For Adult Patients

Date: _____

PATIENT

Patient's Last Name: _____ First Name: _____ Middle initial: _____

I prefer to be called: _____ Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss. ☐ Dr. ☐ Other: _____

Birth Date: _____ Sex: Male ☐ Female ☐ Social Security #: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home address: _____ City, State, Zip code: _____

Home Phone No.: ____- _____-_____ Cell phone: ____- _____-_____ Work phone: ____- _____-_____

Email address(es): _____

Occupation: _____ Employer: _____

CLOSEST RELATIVE

Spouse or closest relative's name(s): _____

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

Address (if different than patient address): _____

Home Phone (if different): ____- _____-_____ 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 (s): _____ City, State: _____

Last seen: _____ Reason: _____ Next Appointment: _____

Most recent physical exam: _____

Other physicians/health care providers being seen now: _____

Name(s): _____ 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 Code: _____

Home Phone (if different): ____- _____-_____ Cell Phone: ____- _____-_____ Email 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 medical history is essential to a complete orthodontic evaluation. *For the following questions, please 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 Cancer, tumor, radiation treatment or chemotherapy?
- ☐ 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 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 problems?
- ☐ Yes ☐ No ☐ dk/u Polio, mononucleosis, tuberculosis, pneumonia?
- ☐ Yes ☐ No ☐ dk/u Seizures, fainting spell, neurologic problem?
- ☐ Yes ☐ No ☐ dk/u Mental health disturbance or depression?
- ☐ Yes ☐ No ☐ dk/u History of eating disorder (anorexia, bulimia)?
- ☐ Yes ☐ No ☐ dk/u Frequent headaches or migraines?
- ☐ Yes ☐ No ☐ dk/u High or low blood pressure?
- ☐ Yes ☐ No ☐ dk/u Excessive bleeding or bruising tendency, 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 Vision, hearing, or speech problems?
- ☐ Yes ☐ No ☐ dk/u Frequent ear infections, colds, throat infections?
- ☐ Yes ☐ No ☐ dk/u Asthma, sinus problems, hay fever?
- ☐ Yes ☐ No ☐ dk/u Tonsil or adenoid condition?
- ☐ Yes ☐ No ☐ dk/u Do you frequently breathe through your mouth?
- ☐ Yes ☐ No ☐ dk/u Have you ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?
- ☐ Yes ☐ No ☐ dk/u Have you ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders?

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

- ☐ Yes ☐ No ☐ dk/u Local anesthetics (novocaine, lidocaine)
- ☐ 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 Foods
- ☐ Yes ☐ No ☐ dk/u Animals
- ☐ Yes ☐ No ☐ dk/u Other Substances

Dental History

Now or in the past, have you had:

- ☐ Yes ☐ No ☐ dk/u Any sensitive or sore teeth?
- ☐ Yes ☐ No ☐ dk/u Bleeding gums, bad taste or mouth odor?
- ☐ Yes ☐ No ☐ dk/u Chipped or injured primary or permanent teeth?
- ☐ Yes ☐ No ☐ dk/u Soreness in jaw muscles or face muscles?
- ☐ Yes ☐ No ☐ dk/u Any lost or broken fillings?
- ☐ Yes ☐ No ☐ dk/u Jaw fractures, cysts, infections?
- ☐ Yes ☐ No ☐ dk/u Any teeth treated with root canals or pulpotomies?
- ☐ Yes ☐ No ☐ dk/u Frequent canker sores or cold sores?
- ☐ Yes ☐ No ☐ dk/u History of speech problems or speech therapy?
- ☐ Yes ☐ No ☐ dk/u Frequent oral habits (sucking finger, chewing pen)?
- ☐ Yes ☐ No ☐ dk/u Teeth causing irritation to lip, cheek or gums?
- ☐ Yes ☐ No ☐ dk/u Tooth grinding or clenching?
- ☐ Yes ☐ No ☐ dk/u Clicking, locking in jaw joints?
- ☐ Yes ☐ No ☐ dk/u Ringing in ears, difficult 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 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?
- ☐ Yes ☐ No ☐ dk/u Any serious trouble associated with previous dental treatment?
- ☐ Yes ☐ No ☐ dk/u Abnormal swallowing (tongue thrust)?
- ☐ Yes ☐ No ☐ dk/u Mouth breathing habit or snoring at night?
- ☐ Yes ☐ No ☐ dk/u Food impaction between the teeth?
- ☐ Yes ☐ No ☐ dk/u Difficulty breathing through nose?
- ☐ Yes ☐ No ☐ dk/u Supernumerary (extra) or congenitally missing teeth?
- ☐ Yes ☐ No ☐ dk/u Permanent or extra (supernumerary) teeth removed?

PATIENT HEALTH INFORMATION

Do you think that any of your activities affect his/her face, teeth or jaws? How? _____

List any medications, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that your child takes.

Medication_____Taken for_____
Medication_____Taken for_____
Medication_____Taken for_____
Does the patient currently have (or ever had) a substance abuse problem? _____
Do you chew or smoke tobacco? _____
Have you noticed any unusual changes in your face or jaws? _____
Any other physical problems? _____

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? _____
How often does your child brush? _____
Floss? _____

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 child's medical or dental health.

Signature_____ Date_____