American Association of Orthodontists®
My Life. My Smile. My Orthodontist.®

CONFIDENTIAL

Medical Dental History Forms for Adult Patients

PATIENT

Date_____

Patient's Last Name _____ First Name _____

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

Birth Date _____ Age_____ ☐ Male ☐ Female Social Security #_____

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

Home Address_____ City, State, Zip _____

☐ Home Phone( )_____ ☐ Cell Phone( )_____ ☐ Work Phone( )_____

(Please check the number you prefer we use for contacting you)

Email Address_____

Occupation _____ Employer_____

DENTIST

Patient's Dentist _____ 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 _____

GENERAL INFORMATION

What concerns you about your teeth? _____

Why did you select our office/who referred you to our office?_____

Have you had any previous orthodontic treatment? Please describe _____

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

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 explain: _____

_____

Do you take antibiotic pre-medication before any dental procedures?_____

Do you or have you ever had a substance abuse problem? _____

Do you chew or smoke tobacco?_____

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

DENTAL INSURANCE

Please provide your insurance card to the front desk person

Primary policy holder's full name_____ Birth Date_____

Insurance company_____ Relationship to patient_____

Social Security # or Insurance Subscriber ID#_____

Secondary policy holder's full name _____ Birth Date_____

Insurance company_____ Relationship to patient_____

Social Security # or Insurance Subscriber ID#_____

Your answers are for our office records only, and are confidential. A thorough medical history is essential to 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?
☐	☐	☐	Bone fractures or major injuries?
☐	☐	☐	Any injuries to the face, head, neck?
☐	☐	☐	Arthritis or joint problems?
☐	☐	☐	Endocrine or thyroid problems?
☐	☐	☐	Diabetes or low blood sugar?
☐	☐	☐	Kidney problems?
☐	☐	☐	Cancer, tumor, radiation treatment or chemotherapy?
☐	☐	☐	Stomach ulcer, hyperacidity, acid reflux?
☐	☐	☐	Immune system problems?
☐	☐	☐	History of osteoporosis?
☐	☐	☐	Gonorrhea, syphilis, herpes, sexually transmitted diseases?
☐	☐	☐	AIDS or HIV positive?
☐	☐	☐	Hepatitis, jaundice, or other liver problems?
☐	☐	☐	Polio, mononucleosis, tuberculosis, pneumonia?
☐	☐	☐	Seizures, fainting spells, neurologic problems?
☐	☐	☐	Mental health disturbance or depression?
☐	☐	☐	Vision, hearing, or speech problems?
☐	☐	☐	History of eating disorder (anorexia, bulimia)?
☐	☐	☐	High or low blood pressure?
☐	☐	☐	Excessive bleeding or bruising, anemia?
☐	☐	☐	Chest pain, shortness of breath, tire easily, swollen ankles?
☐	☐	☐	Heart defects, heart murmur, rheumatic heart disease?
☐	☐	☐	Angina, arteriosclerosis, stroke or heart attack?
☐	☐	☐	Skin disorder (other than common acne)?
☐	☐	☐	Do you eat a well-balanced diet?
☐	☐	☐	Frequent headaches or migraines?
☐	☐	☐	Frequent ear infections, colds, throat infections?
☐	☐	☐	Asthma, sinus problems, hayfever?
☐	☐	☐	Tonsil or adenoid condition?
☐	☐	☐	Do you frequently breathe through your mouth?
☐	☐	☐	Other medical problem? Please explain: _____

_____

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

Yes	No	DK/U	
☐	☐	☐	Local anesthetics (novocaine, lidocaine, xylocaine)
☐	☐	☐	Latex (gloves, balloons)
☐	☐	☐	Aspirin
☐	☐	☐	Metals (jewelry, clothing snaps)
☐	☐	☐	Penicillin
☐	☐	☐	Other antibiotics
☐	☐	☐	Ibuprofen (Motrin, Advil)
☐	☐	☐	Acrylics
☐	☐	☐	Foods
☐	☐	☐	Other substances_____

DENTAL HISTORY

Now or in the past, have you had:

Yes	No	DK/U	
☐	☐	☐	Supernumerary (extra) or congenitally missing teeth?
☐	☐	☐	Chipped or injured primary or permanent teeth?
☐	☐	☐	Any sensitive or sore teeth?
☐	☐	☐	Bleeding gums, bad taste or mouth odor?
☐	☐	☐	Jaw fractures, cysts, infections?
☐	☐	☐	Any teeth treated with root canals or pulpotomies?
☐	☐	☐	History of speech problems or speech therapy?
☐	☐	☐	Difficulty breathing through nose?
☐	☐	☐	Food impaction between the teeth?
☐	☐	☐	Mouth breathing habit or snoring at night?
☐	☐	☐	Frequent oral habits (sucking finger, chewing pen, etc)?
☐	☐	☐	Abnormal swallowing (tongue thrust)?
☐	☐	☐	Tooth grinding or clenching?
☐	☐	☐	Clicking, locking in jaw joints?
☐	☐	☐	Soreness in jaw muscles or face muscles?
☐	☐	☐	Have you ever been treated for "TMJ" or "TMD" problems?
☐	☐	☐	Any serious trouble associated with previous dental treatment?
☐	☐	☐	Have your ever been diagnosed with gum disease or pyorrhea?
☐	☐	☐	Have you ever had an orthodontic consultation or treatment

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 _____