**American Association of Orthodontist®s**

**b d**

# Medical Dental History Form

## CONFIDENTIAL

My Life. My Smile. My Orthodontist.®

# for Adult Patients

**\*\*BLUE OR BLACK INK PLS\*\***

## PATIENT

Date \_ Patient's last name \_

First name \_ \_

\_ \_ \_ \_ \_

\_ \_ \_ \_ \_

Middle initial \_

Title Mr. Mrs. Ms. Miss. Dr. Other \_

I prefer to be called \_ \_ \_ \_

\_ \_ \_

\_ \_ \_ \_ \_

\_ \_ \_ \_

\_ \_ \_ \_

Birth date \_ \_ \_ \_

\_ \_ \_ Sex D Male D Female Social Security# \_ \_ \_

\_ \_ \_

\_ \_ \_

\_ \_ \_ \_ \_

\_ \_ \_ \_ \_ \_ \_

Marital Status D Single D Married D Separated □Divorced D Widowed

Home address \_ \_

\_ \_ \_

\_ \_ \_

\_ \_ \_ \_ \_

\_ City, State, Zip code \_ \_ \_

\_ \_ \_ \_ \_

\_ \_ \_ \_ \_

\_ \_ \_

\_ \_ \_ \_

Home phone ( Cell phone ( Work phone (

Email Address(es)

Occupation

Employer \_ \_ \_ \_ \_

\_ \_ \_ \_ \_ \_

\_ \_ \_ \_ \_

\_ \_ \_ \_ \_ \_ \_ \_

## CLOSEST RELATIVE

Spouse or closest relatives 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 \_ \_

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Reaso\_n \_ \_

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## PHYSICIAN

Patient's Physician \_

City, State \_ \_

\_ \_ \_

\_ \_ \_ \_ \_

\_ \_ \_ \_ \_

\_ \_ \_

\_ \_ \_ \_ \_

Last seen \_ \_ \_ \_

\_ \_ \_

\_ \_ \_ \_ \_

\_ \_ \_ \_

Reason \_ \_ \_

\_ \_ \_

\_ \_ \_

\_ \_ \_

\_ Next appointment \_

Most recent physical exam - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

Other physicians / health care providers being seen now:

Nam\_e \_ \_ \_ \_ \_ \_ \_

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City, State \_ \_

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City, State

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### GENERAL INFORMATION

What concerns you about your teeth? - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

Who suggested that you might need orthodontic treatment?

Why did you select our office? \_

\_ \_ \_ \_ \_

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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 than page 1)* \_ City, State, Zip \_

Home phone (

Cell phone (

Email address(es) \_

Social Security#\_ \_ \_

\_ \_ \_ \_ \_

\_ \_ \_ \_ \_ \_

Employer

#### Please provide ALL insurance info

**DENTAL INSURANCE**

Primary policy holder 's full name \_ \_ \_

\_ \_ \_ \_ \_

\_ \_ \_ \_ \_

\_ \_ \_ \_ \_

\_ \_ \_ \_

\_ \_ \_

Birth date \_

Social Security#\_ \_ \_

\_ \_ \_ \_ \_

\_ \_ \_ \_ \_ \_

Relationship to patient

Address and phone (if not listed above) - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

Employer \_ \_ \_ \_ \_ \_

\_ \_ \_

\_ \_ \_

\_ \_ \_ \_

Address \_

Insurance company Group# Does this policy have orthodontic benefits? □Yes □No D Don't Know

ID# \_

Secondary policy holder's full name

Birth date \_

Social Security# Relationship to patient Address and phone (if not listed above) Employer Address

Insurance company Group# Does this policy have orthodontic benefits? □Yes □No D Don't Know

ID# \_

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

**Now or In the past, have you had:** Yes No DK/U

Yes No DK/U □ □ □ Local anesthetics (novocaine, lidocaine, xyloca ine)

* □ □ Birth defects or hereditary problems? □ □ □ Latex (gloves , balloons)
* □ □ Bone fractures or major injuries? □ □ □ Asp irin
* □ □ Any injuries to face, head, neck? □ □ □ Metals Oewelry, clothing snaps)
* □ □ Arthritis or joint problems? □ □ □ Penicillin
* □ □ Endocrine or thyroid problems? □ □ □ Other antibiotics
* □ □ Diabe tes or low sugar? □ □ □ Ibuprofen (M otrin, Advil)
* □ □ Kidney problems? □ □ □ Acrylics
* □ □ Cancer, tumor, radiation treatment or chemotherapy? □ □ □ Plant pollens
* □ □ Stomach ulcer, hyperacidity, acid reflux? □ □ □ Animals
* □ □ Immune system problems? □ □ □ Foods
* □ □ History of osteoporosis? □ □ □ Other substances
* □ □ Gonorrhea, syphilis, herpes, sexually transm itt ed diseases?
* □ □ AID S or HIV positive? **DENTAL HISTORY**
* □ □ Hepatitis, jaundice, or other liver problems? **Now or in the past, have you had:**
* □ □ Polio, mononuc leosis, tuberculosis, pneumonia? Yes No DK/U
* □ □ Seizures, fainting spells, neurologic problems? □ □ □ Permanent or extra (supernumerary) teeth removed?
* □ □ Menta l health disturbance or depression? □ □ □ Supernumerary (extra) or congenitally missing teeth?
* □ □ Vis ion, hearing, or speech problems? □ □ □ Chipped or injured primary or permanent teeth?
* □ □ History of eating disorder (anorexia, bu limia)? □ □ □ Any sensitive or sore teeth?
* □ □ High or low blood pressure? □ □ □ Bleeding gums, bad taste or mouth odor?
* □ □ Excessive bleed ing or bruising, anemia? □ □ □ Jaw fractures , cysts, infections?
* □ □ Chest pain, shortness of breath, tire easily, swollen ankles? □ □ □ Any teeth treated with root canals or pulpotomies?
* □ □ Heart defects, heart murmur, rheumatic heart disease? □ □ □ " Gum boils, " frequent canker sores or cold sores?
* □ □ Angi na, arter iosc ler osis, stroke or heart attack? □ □ □ History of speech problems or speech therapy?
* □ □ Skin disorder (other than common acne)? □ □ □ Difficulty breathing through nose?
* □ □ Do you eat a well-balanced diet? □ □ □ Food impaction between the teeth?
* □ □ Frequent headac hes or migraines? □ □ □ Mouth breathing habit or snoring at night?
* □ □ Frequent ear infections, colds, throat infections? □ □ □ Frequent oral habits (sucking finger, chewing pen, etc)?
* □ □ Asthma, sinus problems, hayfever? □ □ □ Teeth causing irritation to lip, cheek or gums?
* □ □ Tonsil or adenoid condition? □ □ □ Abnormal swallowing (tongue thrust)?
* □ □ Do you frequent ly breathe through your mouth? □ □ □ Tooth grinding or clenching?
  + □ □ Clicking, locking in jaw joints?
  + □ □ Soreness in jaw musc les or face muscles?
  + □ □ Ringing in ears , difficulty in chewing or opening jaw?
  + □ □ Have you ever been treated for "TMJ" or "TMD" problems?
  + □ □ Any broken or missing fillings?
  + □ □ Any serious trouble associated with previous dental treatment?
  + □ □ Have you ever been diagnosed with gum disease or pyorrhea?
  + □ □ Have you ever had an orthodontic consultation or treatment before now?

## PATIENT HEALTH INFORMATION

List any medication , nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements , that you take .

Medication \_ \_ \_

\_ \_ \_

\_ \_ \_ \_

\_ \_ \_ \_ \_ \_

Taken for \_ \_

\_ \_ \_ \_

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\_ \_ \_ \_

\_ \_ \_

\_ \_ \_

\_ \_ \_ \_ \_ \_

Medication \_

Taken for \_ \_

\_ \_ \_ \_ \_ \_ \_

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Medication \_ \_ \_

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\_ \_ \_

Taken for \_ \_ \_ \_

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Have you ever ta ken any medications to strengthen your bones? Please describe. \_ \_

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Do you take antibiotic pre-medicat ion before any dental procedures? \_ \_

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Do you or have you ever had a substance abuse problem? \_ \_ \_ \_ \_ \_

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Do you chew or smoke tobacco? ­

Have you noticed any changes in your face or jaws? ­

Any other physical problems? - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

How often do you brush ? \_ \_

\_ \_ \_ \_ \_ \_ \_ \_ \_

How often do you floss? \_ \_ \_

\_ \_ \_

\_ \_ \_ \_ \_ \_ \_ \_

\_ \_ \_ \_ \_

Women : Are you pregnant? D Yes D No Are you trying to become pregnant? D Yes D No

## FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following health problems? If so, please explain. \_ \_ \_

\_ \_ \_ \_ \_ \_ \_ \_ \_ \_

\_ \_ \_

Bleeding disorders \_

Diabetes \_ \_

\_ \_ \_ \_

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Arthrit is \_ \_

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\_ \_ \_

Severe allergies \_ \_

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Unusual dental problems \_

Jaw size imbalance \_ \_ \_ \_

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Other famil y medi cal conditions? - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

## RELEASE AND WAIVER

##### I authorize release of any Information regarding my orthodontic treatment to my dental and/or med/cal Insurance company.

Signature - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - Date

##### I have read the above questions and understand them. I wlll 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 wlll notify my orthodontist of any changes In my med/cal or dental health.

S gi na t ur e - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - Date

## MEDICAL HISTORY UPDATES OR CHANGES

Change\_s \_ \_ \_ \_

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S gi na tur e ----------------------------------

Date \_

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Dental Staff Signature \_ \_

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Date \_ \_

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Dental Staff Signature \_ \_

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Signature - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

Date \_

Dental Staff Signature \_ \_ \_ \_ \_ \_

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Date \_ \_

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