

## Adult Dental History Form

Patient's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name / Initial \_\_\_\_\_

Patient's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Cell Phone No. \_\_\_\_\_ Business Phone No. \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Years with Employer \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex: Male  Female  Social Security No. \_\_\_\_\_

Marital Status: Single  Married  Separated  Divorced  Widowed

Names and ages of other family members who could benefit from Orthodontic treatment: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Name of Patient's Dentist \_\_\_\_\_ Phone No. \_\_\_\_\_ Date of last Dental Cleaning \_\_\_\_\_

Do you have insurance coverage for orthodontic treatment? Yes  No

Primary Policy Holder's Name \_\_\_\_\_ Social Security No. \_\_\_\_\_

Date of Birth \_\_\_\_\_ Employed by \_\_\_\_\_

Dental Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_

Secondary Policy Holder's Name \_\_\_\_\_ Social Security No. \_\_\_\_\_

Date of Birth \_\_\_\_\_ Employed by \_\_\_\_\_

Dental Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_

### MEDICAL HISTORY

**For the following questions, mark Yes, No, or Don't Know/Understand (DK/U). Your answers are for our office records only, and will be considered confidential. Answers to these questions are vital to a proper orthodontic evaluation.**

**Do you have allergies or reactions to any of the following?**

Yes  No  DK/U Local anesthetics (Novocaine or Lidocaine)

Yes  No  DK/U Penicillin or other antibiotics

E-mail Address: \_\_\_\_\_

Yes  No  DK/U Metals (jewelry, clothing snaps)

Yes  No  DK/U Latex (gloves, balloons)

(Over)

**Are you taking medications, nutrient supplements, herbal medications, or non-prescription medicines?  
If yes, please name them.**

Medication \_\_\_\_\_ Taken for \_\_\_\_\_

Medication \_\_\_\_\_ Taken for \_\_\_\_\_

**Have you been treated for any of the following?**

- |                              |                             |                               |                                  |                              |                             |                               |                        |
|------------------------------|-----------------------------|-------------------------------|----------------------------------|------------------------------|-----------------------------|-------------------------------|------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Diabetes, Kidney problems        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Asthma                 |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Prolonged bleeding               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Allergies              |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Arthritis                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Hormonal abnormalities |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Heart disorder or heart murmur   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Nervous disorders      |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Joint or heart valve replacement | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Rheumatic fever        |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Throat or nose problems          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Ear problems           |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Abnormal blood pressure          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Eye problems, Glaucoma |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | AIDS, HIV infection              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Hepatitis, Jaundice    |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Tonsillitis                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Epilepsy, seizure      |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Brain injury or stroke           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Tuberculosis           |

Explanation: \_\_\_\_\_

**WOMEN ONLY:**

Yes  No  DK/U Are you pregnant?

**DENTAL HISTORY**

**Now, or in the past, have you had:**

- Yes  No  DK/U Periodontal "gum problems"?
- Yes  No  DK/U Have you ever been treated for "TMD" or "TMJ" problems?
- Yes  No  DK/U Ever had a prior orthodontic examination or treatment?

I have read and understand the above questions. 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. If there are any changes later to this history record or my medical/dental status, I will so inform this practice.

Patient's Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

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**MEDICAL HISTORY UPDATE or CHANGES  No Changes**

Explain changes \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_ Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL HISTORY UPDATE or CHANGES  No Changes**

Explain changes \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_ Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL HISTORY UPDATE or CHANGES  No Changes**

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Explain changes \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_ Staff Signature \_\_\_\_\_ Date \_\_\_\_\_