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

CONFIDENTIAL

Medical Dental History Form for Adult Patients

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: Male ☐ Female ☐ Social Security # ______- ______ - ______

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

Home address ______ City, State, Zip code ______

Cell phone (______)______- ______ Home phone (______)______- ______

Work phone (______)______-______

E-mail 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)* ______

Cell phone (______)______- ______ Home 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 ______ City, State ______

Last seen ______ Reason ______ Next appointment ______

Most recent physical exam ______

Other physicians/health care providers being seen now:

Name ______ City, State ______ Reason ______

Name ______ City, State ______ Reason ______

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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? ______

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 ______

Cell phone (______)______-______ Home phone (______)______-______

E-mail 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 ______

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Your answers are for office records only, and are confidential. A thorough medial history is essential to a complete orthodontic evaluation. For the following questions 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 Endocrine or thyroid problems?
- ☐ yes ☐ no ☐ dk/u Diabetes or low sugar?
- ☐ yes ☐ no ☐ dk/u Kidney problems?
- ☐ yes ☐ no ☐ dk/u Cancer, tumor, radiation treatment or chemotherapy?
- ☐ 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 problem?
- ☐ yes ☐ no ☐ dk/u Polio, mononucleosis, tuberculosis, pneumonia?
- ☐ yes ☐ no ☐ dk/u Seizures, fainting spells, neurologic problem?
- ☐ yes ☐ no ☐ dk/u Mental health disturbance or depression?
- ☐ yes ☐ no ☐ dk/u Vision, hearing, or speech problems?
- ☐ yes ☐ no ☐ dk/u History of eating disorder (anorexia, bulimia)?
- ☐ yes ☐ no ☐ dk/u High or low blood pressure?
- ☐ yes ☐ no ☐ dk/u Excessive bleeding or bruising, 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 Frequent headaches or migraines?
- ☐ yes ☐ no ☐ dk/u Frequent ear infections, colds, throat infections?
- ☐ yes ☐ no ☐ dk/u Asthma, sinus problems, hayfever?
- ☐ yes ☐ no ☐ dk/u Tonsil or adenoid condition?
- ☐ yes ☐ no ☐ dk/u Do you frequently breathe through your mouth?

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

- ☐ yes ☐ no ☐ dk/u Local anesthetics (novocaine, lidocaine, xylocaine)
- ☐ 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 Animals
- ☐ yes ☐ no ☐ dk/u Foods
- ☐ yes ☐ no ☐ dk/u Other substances ______

DENTAL HISTORY

Now or in the past, have you had:

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

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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 ______ Medication ______ Taken for ______

Have you ever taken any medications to strengthen your bones? Please describe. ______

Do you take antibiotic pre-medication before any dental procedures? ☐ Yes ☐ No

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

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? ☐ Yes ☐ No Are you trying to become pregnant? ☐ Yes ☐ No

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? ______

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________________

MEDICAL HISTORY UPDATES OR CHANGES

Changes ______
Patient Signature ____ Date________________
Dental Staff Signature ____ Date________________

Changes ______
Patient Signature ____ Date________________
Dental Staff Signature ____ Date________________

Changes ______
Patient Signature ____ Date________________
Dental Staff Signature ____ Date________________

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