American Association of Orthodontics
MEDICAL DENTAL HISTORY FORM – ADULT

CONFIDENTIAL

Date: _____

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

Birth Date:_____ **Age:**_____ **Sex:** M F **Email Address:** _____

Address: _____ **City:** _____ **State**: _____ **Zip**:_____

Home Phone: _____ **Work Phone**: _____ **Cell Phone**:_____

Patient is: **Single** **Married** **Separated** **Divorced**

Name of Spouse/Closest Relative: _____ **Relationship to you:** _____

Occupation: _____ **Employer**: _____

Name of Patient's Dentist: _____

Dentist Address: _____

State: _____ **Zip:** _____ **Phone #:** _____

Date Last Seen: _____ **Reason:** _____

Name of Patient's Physician: _____

Physician's Address: _____ **City**: _____

State: _____ **Zip:** _____ **Phone #:** _____

Date Last Seen: _____ **Reason**: _____

Who Referred You To Our Office: _____

Insurance Coverage for Orthodontic Treatment: **Y** **N**

Primary Dental Ins. Co.: _____ **Group ID#:** _____ **Plan ID#:** _____

Policy Holder's Name: _____ **Policy Holder's Employer Name:** _____

Policy Holder's DOB: _____ **/** _____ **/**_____ **Policy Holder's Social Security #:** _____ - _____- _____

Secondary Dental Ins. Co.: _____ **Group ID#:** _____ **Plan ID#:** _____

Policy Holder's Name: _____ **Policy Holder's Employer Name:** _____

Policy Holder's DOB: ___/ ____ / _____ **Policy Holder's Social Security #:** _____ - ____ - _____

In Case We Cannot Reach You-- Person to Contact: _____ **Phone #:** _____

(TURN OVER TO COMPLETE PAGE 2)

For the following questions mark yes or no. The answers are for the office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

MEDICAL HISTORY

Yes No Birth defects or hereditary problems?
Yes No Bone Fractures, any major accidents?
Yes No Rheumatoid or arthritic conditions?
Yes No Endocrine or thyroid problems?
Yes No Kidney problems?
Yes No Diabetes?
Yes No Cancer, tumor, radiation treatment or Chemotherapy?
Yes No AIDS or HIV positive?
Yes No Hepatitis, jaundice, or liver problems?
Yes No Fainting spells, seizures, epilepsy, or Neurological problem?
Yes No Mental health disturbance or depression?
Yes No Vision, hearing, tasting, or speech Difficulties?
Yes No History of eating disorder (anorexia, bulimia)?
Yes No Excessive bleeding or bruising tendency, anemia or bleeding disorder?
Yes No High or low blood pressure?
Yes No Hay fever, asthma, sinus, trouble, or hives?
Yes No Tonsil or adenoid conditions?
Yes No Has patient ever been hospitalized?
Yes No Cardiovascular problem (heart trouble, Heart attack, angina, coronary insufficiency, atherosclerosis, stroke, inborn heart defects, heart murmur, or rheumatic heart disease)?

DENTAL HISTORY

Yes No Chipped or otherwise injured permanent teeth?
Yes No Teeth sensitive to hot or cold; teeth throb or ache?
Yes No Jaw fractures, cysts or mouth infections?
Yes No "Dead teeth" or root canals treated?
Yes No Periodontal "gum problems"?
Yes No Food impaction between teeth?
Yes No Thumb, finger, or sucking habit? Until what age _____?
Yes No Abnormal swallowing habit (tongue thrusting)?
Yes No Have you ever been treated for "TMJ" problems?
Yes No Tooth grinding or jaw clenching?
Yes No Any pain in jaw or ringing in the ears?
Yes No Difficulty encountered in chewing or jaw opening?
Yes No Concerned about spaced, crooked, or protruding teeth?
Yes No "Gum boils", frequent canker sores or cold sores?
Yes No Any relative with similar tooth or jaw relationships?
Yes No Would you object to wearing orthodontic (braces) should they be indicated?
Yes No Any serious trouble associated with any previous dental treatment?
Yes No Ever had a prior orthodontic examination or treatment?
Yes No Been under another dentist's Care?
Specialist? _____

Women Only:

Yes No Are you pregnant?

Allergies or reaction to any of the following medications: Aspirin, Ibuprofen, Penicillin, Latex (gloves), Others (specify): _____

How often do you brush: Floss:
What is your primary concern? Why are you here? _____

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 medical/dental status, I will inform this practice.

Signed: _____
Dated Signed: _____