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Specialist in Orthodontics
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MEDICAL HISTORY FORM
ADULT PATIENTS

Patient's Name: Prefer to be called:
LAST FIRST MIDDLE

Age: Date of Birth: Sex: ( ) Male ( ) Female

Address: City: State: Zip:

Home Phone #: Work Phone #:

Marital Status: Single ( ) Married ( ) Widowed ( ) Separated ( ) Divorced ( ) Remarried ( )

Employer:

Person responsible for this account: S.S.#:

Address (if different):

Dentist's name: Phone #: Date of last visit:

Physician's name: Phone #:

What concerns about your teeth brought you to our office?

Insurance Company: Subscriber's S.S.#:

Who may we thank for referring you?

PLEASE CHECK THE FOLLOWING AS THEY APPLY:

Medical History

( ) Allergies or asthma
( ) Allergy to latex / metals
( ) Heart disease
Requiring pre-medication Y / N
( ) High blood pressure
( ) Cancer
( ) Rheumatic fever
( ) Blood Disorders
( ) Hepatitis
( ) Tuberculosis (TB)
( ) Women: are you pregnant?
( ) Arthritis
( ) Tonsils Removed
( ) Epilepsy
( ) AIDS antibody positive
( ) Liver or kidney disorders
( ) Diabetes
( ) Nail or lip biting

Dental History

( ) Extra or missing teeth
( ) Speech problems
( ) Trauma to face, jaws or teeth
( ) Cleft lip or palate
( ) Clenching or grinding of teeth
( ) Problems or pain associated with muscles or joints of your jaws
( ) Periodontal disease
( ) Previous orthodontic care

Do you regularly receive any medication and/or medical treatment? ( )Yes ( )No If yes, for what reason:

Have you ever had an unfavorable reaction to any drugs, antibiotics, or anesthetics? ( )Yes ( )No If yes, specify:

Do you have a history of any serious illness, accident or operation? ( )Yes ( )No If yes, please give details:

Have you ever taken Fosomax or any other Bisphosphonate? ( ) Yes ( ) No:

Other significant physical or mental health considerations (past or present):

I have read and understand the above questions. The information provided is accurate to the best of my knowledge . 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. It is my responsibility to notify this practice if there are any changes later to this history record or medical/dental status.

Signature of patient Date

Yes, I would like to receive email appointment reminders **Email Address**_____

Thank you for your cooperation. The above information is important in your diagnosis and treatment, and will be kept in **strict confidence.**

Office use: Medical/dental information above reviewed with patient. Initials _____ Date _____

Comments: _____

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