American Association of Orthodontists®

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 _____

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 _____

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 Have you ever taken intravenous medication for bone disorders or cancer such as bisphosphonates as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate)?

☐ yes ☐ no ☐ dk/u Have you ever taken oral medication for bone disorders such as bisphosphonates Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate)?

☐ 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 Latex (gloves, balloons)

☐ yes ☐ no ☐ dk/u Metals (jewelry, clothing snaps)

☐ yes ☐ no ☐ dk/u Acrylics

☐ yes ☐ no ☐ dk/u Local anesthetics (novocaine, lidocaine, xylocaine)

☐ 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 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

PATIENT HEALTH INFORMATION

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

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

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 or have you ever had a substance abuse problem? _____

Have you chewed tobacco ☐ Yes ☐ No or smoked any substance or vaped? ☐ Yes ☐ No

If yes, what is the frequency? _____

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_____