TODAY'S DATE _____

MEDICAL DENTAL HISTORY FORM
ADULTS

Delivering Amazing Smiles & Exceptional Service

CONFIDENTIAL

MR ☐ MRS ☐ MS ☐ MISS ☐ REV ☐ DR ☐

PATIENT NAME (First) _____ (Middle) _____ (Last) _____

Home Address _____

City _____ State _____ Zip _____ Home Phone No. _____

Social Security # _____ -_____ _____

E-Mail Address _____ Cell Phone No. _____

Birthdate ____ / ____ / ____ Age _____ Sex M ☐ F ☐ Marital Status _____

Family Members Treated Here _____

Occupation _____ Employer _____ Business Phone No. _____

Who suggested you might need orthodontic treatment? _____

Why did you select our office? _____

Emergency Contact _____ Relationship _____ Phone No. _____

Name of Patient's Dentist _____ Phone No. _____

Dentist Address _____ City _____ State ____ Zip _____

Date Last Seen ____ / ____ / ____ Reason _____

Name of Patient's Physician _____ Phone No. _____

Physician's Address _____ City _____ State ____ Zip _____

Date Last Seen ____ / ____ / ____ Reason _____

MR ☐ MRS ☐ MS ☐ MISS ☐ REV ☐ DR ☐

SPOUSE NAME: _____

Address: _____ City _____ State ____ Zip _____

Home Phone No. _____ Cell Phone No. _____ E-Mail Address _____

Birth Date ____ / ____ / ____ Social Security No. (for insurance purposes only) _____ - _____ - _____

Employer _____ Occupation _____

OTHER RESPONSIBLE PARTY NAME: (If patient not responsible) _____ Relationship _____

Address: _____ City _____ State ____ Zip _____

Home Phone No. _____ Cell Phone No. _____ E-Mail Address _____

Birth Date ____ / ____ / ____ Social Security No. (for insurance purposes only) _____ - _____ - _____

Employer _____ Occupation _____ Marital Status _____

INSURANCE INFORMATION

(Please supply a copy of your card to our Receptionist)

INSURANCE COVERAGE FOR DENTAL TREATMENT? YES ❑ NO ❑ INSURANCE COVERAGE FOR ORTHODONTIC TREATMENT? YES ❑ NO ❑

PRIMARY Policy Holder's Name _____ Birthdate ____ / ____ / ____

SSN or ID NO: _____ - _____ - _____ Employed by _____

Dental Insurance Co. Name _____ Customer Service Phone No. _____

Claims Address_____ City _____ State _____ Zip _____

Group Name _____ Group No. _____

SECONDARY Policy Holder's Name _____ Birthdate ____ / ____ / ____

SSN or ID NO: _____ - _____ - _____ Employed by _____

Dental Insurance Co. Name _____ Customer Service Phone No. _____

Claims Address_____ City _____ State _____ Zip _____

Group Name _____ Group No. _____

MEDICAL HISTORY

(FOR THE FOLLOWING QUESTIONS, MARK "YES", "NO" , OR "DON'T KNOW/UNDERSTAND" (dk/u).
THE ANSWERS ARE FOR OFFICE RECORDS ONLY AND WILL BE CONSIDERED CONFIDENTIAL.
A THOROUGH AND COMPLETE HISTORY IS VITAL TO A PROPER ORTHODONTIC EVALUATION.

Now, or in the past, have you had:

❑ yes ❑ no❑ dk/u Birth defects or hereditary problems?
❑ yes ❑ no❑ dk/u Bone fractures, any major accidents?
❑ yes ❑ no❑ dk/u Rheumatoid or arthritic condition?
❑ yes ❑ no❑ dk/u Endocrine or thyroid problems?
❑ yes ❑ no❑ dk/u Kidney problems?
❑ yes ❑ no❑ dk/u Diabetes?
❑ yes ❑ no❑ dk/u Cancer, tumor, radiation treatment, or chemotherapy?
❑ yes ❑ no❑ dk/u Stomach ulcer or hyperacidity?
❑ yes ❑ no❑ dk/u Polio, mononucleosis, tuberculosis, pneumonia?
❑ yes ❑ no❑ dk/u Problems of the immune system?
❑ yes ❑ no❑ dk/u AIDS or HIV positive?
❑ yes ❑ no❑ dk/u Hepatitis, jaundice or liver problems?
❑ yes ❑ no❑ dk/u Fainting spells, seizures, epilepsy or neurological problem?
❑ yes ❑ no❑ dk/u Mental health disturbance or depression?
❑ yes ❑ no❑ dk/u Vision, hearing, tasting or speech difficulties?
❑ yes ❑ no❑ dk/u Loss of weight recently, poor appetite?
❑ yes ❑ no❑ dk/u History of eating disorder (anorexia, bulimia)?
❑ yes ❑ no❑ dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?
❑ yes ❑ no❑ dk/u High or low blood pressure?
❑ yes ❑ no❑ dk/u Tired easily?
❑ yes ❑ no❑ dk/u Chest pain, shortness of breath or swelling ankles?
❑ yes ❑ no❑ dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease?
❑ yes ❑ no❑ dk/u Skin disorder?
❑ yes ❑ no❑ dk/u Do you have a well-balanced diet?
❑ yes ❑ no❑ dk/u Frequent headaches, colds or sore throats?
❑ yes ❑ no❑ dk/u Eye, ear, nose or throat condition?
❑ yes ❑ no❑ dk/u Hay fever, asthma, sinus trouble or hives?
❑ yes ❑ no❑ dk/u Tonsil or adenoid conditions?
❑ yes ❑ no❑ dk/u Osteoporosis?

Allergies or reactions to any of the following:

❑ yes ❑ no❑ dk/u Local Anesthetics (Novocaine or Lidocaine)
❑ yes ❑ no❑ dk/u Aspirin

❑ yes ❑ no❑ dk/u Ibuprofen (Motrin, Advil)
❑ yes ❑ no❑ dk/u Penicillin or other antibiotics
❑ yes ❑ no❑ dk/u Sulfa drugs
❑ yes ❑ no❑ dk/u Codeine or other narcotics
❑ yes ❑ no❑ dk/u Metals (jewelry, clothing snaps)
❑ yes ❑ no❑ dk/u Latex (gloves, balloons)
❑ yes ❑ no❑ dk/u Vinyl
❑ yes ❑ no❑ dk/u Acryic
❑ yes ❑ no❑ dk/u Animals
❑ yes ❑ no❑ dk/u Foods (specify) _____
_____
❑ yes ❑ no❑ dk/u Other substances (specify)_____
_____
❑ yes ❑ no❑ dk/u Are you currently taking or have you ever taken any intravenous bisphosphonates for serious bone disorders/ cancers, such as Zometa (zolendronic acid), Aredia (pamidronate), Didronel (etidromate)?
❑ yes ❑ no❑ dk/u Are you currently taking or have you ever taken any oral bisphosphonates for osteoporosis, osteopenia or other uses, such as Fosamax (alendronate), Actonel (risendronate), Boniva (ibandronate), Skelid (tiladronate), Didronel (etidronate)? Please name the medication and length of time on the medication.

Medication _____length of time taken _____
Medication _____length of time taken _____

❑ yes ❑ no❑ dk/u Are you taking medication, nutrient supplements, herbal medications or non-prescription medicine? Please name them.

Medication _____ taken for _____
Medication _____ taken for _____
Medication _____ taken for _____
Medication _____ taken for _____
Medication _____ taken for _____
Medication _____ taken for _____
Medication _____ taken for _____

❑ yes ❑ no❑ dk/u Do you currently have or ever had a substance abuse problem?
❑ yes ❑ no❑ dk/u Do you chew or smoke tobacco?
❑ yes ❑ no❑ dk/u Operations? Describe _____
_____
❑ yes ❑ no❑ dk/u Hospitalized? Describe _____
_____
❑ yes ❑ no❑ dk/u Other physical problems or symptoms?
Describe _____
_____

❑ yes ❑ no❑ dk/u Being treated by another health care professional?
For: _____
Date of most recent physical exam:
_____

Do you have any other medical conditions that we should know about? _____
_____

WOMEN ONLY

❑ yes ❑ no❑ dk/u Are you pregnant?
❑ yes ❑ no❑ dk/u Are you anticipating becoming pregnant?

FAMILY MEDICAL HISTORY

Do your parents or siblings have, or have ever had any of the following health problems? If so, please explain.

Bleeding disorders _____
Diabetes _____
Arthritis _____
Severe allergies _____
Unusual dental problems _____
Jaw size imbalance _____
Any other family medical conditions that we should know about? _____
_____

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 otherwise injured primary (baby) or permanent teeth?
❑ yes ❑ no❑ dk/u Teeth sensitive to hot or cold, teeth throb or ache?
❑ yes ❑ no❑ dk/u Jaw fractures, cysts or mouth infections?
❑ yes ❑ no❑ dk/u "Dead teeth" or root canals treated?
❑ yes ❑ no❑ dk/u Bleeding gums, bad taste or mouth odor?
❑ yes ❑ no❑ dk/u Periodontal "gum problems"?
❑ yes ❑ no❑ dk/u Food impaction between teeth?
❑ yes ❑ no❑ dk/u "Gum boils", frequent canker sores or cold sores?
❑ yes ❑ no❑ dk/u Thumb, finger or sucking habit? Until what age _____ ?

❑ yes ❑ no❑ dk/u	Abnormal swallowing habit (tongue thrusting)?	❑ yes ❑ no❑ dk/u	Concerned about spaced, crooked or protruding teeth?
❑ yes ❑ no❑ dk/u	History of speech problems?	❑ yes ❑ no❑ dk/u	Aware or concerned about under or over developed jaw?
❑ yes ❑ no❑ dk/u	Mouth breathing habit, snoring or difficulty in breathing?	❑ yes ❑ no❑ dk/u	Any relative with similar tooth or jaw relationships?
❑ yes ❑ no❑ dk/u	Tooth grinding or jaw clenching?	❑ yes ❑ no❑ dk/u	Any wisdom tooth problems?
❑ yes ❑ no❑ dk/u	Any pain, clicking or locking in jaw or ringing in the ears?	❑ yes ❑ no❑ dk/u	Had periodontal (gum) treatment?
❑ yes ❑ no ❑ dk/u	Any pain or soreness in the muscles of the face or around the ears?	❑ yes ❑ no❑ dk/u	Had any serious trouble associated with any previous dental treatment?
❑ yes ❑ no ❑ dk/u	Difficulty in chewing or jaw opening?	❑ yes ❑ no❑ dk/u	Been under another dentist's care?
❑ yes ❑ no ❑ dk/u	Have you ever been treated for "TMD" or "TMJ" problems?		Specialist _____ Other _____
❑ yes ❑ no ❑ dk/u	Aware of loose, broken or missing restoration (fillings)?	❑ yes ❑ no❑ dk/u	Ever had a prior orthodontic examination or treatment?
❑ yes ❑ no ❑ dk/u	Any teeth irritating cheek, lip, tongue or palate?	❑ yes ❑ no❑ dk/u	Would you object to wearing orthodontic appliances (braces) should they be indicated?

How often do you brush? _____ floss? _____

What is your primary concern? Why are you here? _____

We regularly extend a monthly payment plan option to our patients. Please indicate to us if you would like to be considered for this option or other outside financing:

☐ YES, I am interested in obtaining a no interest payment plan from this office and authorize a check of my credit to determine the options available to me.

☐ NO, I am not interested in a payment plan at this time.

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 so inform this practice.

Signed: _____ Date Signed: _____
(Patient)

Signed: _____ Date Signed: _____
(Dental Staff Member)

Brown Orthodontics

Where Smiles Happen

Delivering Amazing Smiles and Exceptional Service

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