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 _____