

# MEDICAL DENTAL HISTORY FORM - ADULT

## PERSONAL HISTORY

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ I Prefer to be Called: \_\_\_\_\_

Birth Date (M/D/Y): \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male  Female  Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Work #: \_\_\_\_\_

Dentist: \_\_\_\_\_ Cell #: \_\_\_\_\_

Other Family Members Treated Here: \_\_\_\_\_ Email: \_\_\_\_\_

Whom May We Thank For Referring you? \_\_\_\_\_

## INSURANCE INFORMATION

Name of <b>Primary</b> Insurance Company:		Employer:		Group/Policy #	
Name of Insured:		Birth Date M/D/Y		ID/Cert. #	
Name of <b>Second</b> Insurance Company:		Employer:		Group/Policy #	
Name of Insured:		Birth Date M/D/Y		ID/Cert. #	

## MEDICAL HISTORY:

Name of Patient's Physician: \_\_\_\_\_ Date of Last Medical Check-up: \_\_\_\_\_

Are you currently being treated for a medical condition.....  Y  N Please Explain: \_\_\_\_\_

Have you ever been hospitalized.....  Y  N Please Explain: \_\_\_\_\_

Have you had any operations.....  Y  N Please List: \_\_\_\_\_

Physical problems or symptoms we should be aware of.....  Y  N Please Explain: \_\_\_\_\_

Have you ever had your tonsils/adenoids removed.....  Y  N At What Age? \_\_\_\_\_

Are you a smoker.....  Y  N

Do you have any allergies (metals, medications, latex products etc.).....  Y  N Please List \_\_\_\_\_

**WOMEN ONLY:**

Are you pregnant or think you may be pregnant.....  Y  N Due Date: \_\_\_\_\_

### NOW OR IN THE PAST HAS YOU EVER HAD:

Cancer, tumor, radiation or chemotherapy.....	<input type="checkbox"/> Y <input type="checkbox"/> N	HIV positive or AIDS.....	<input type="checkbox"/> Y <input type="checkbox"/> N
Birth defects or hereditary problems.....	<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis, jaundice or liver problem.....	<input type="checkbox"/> Y <input type="checkbox"/> N
Excessive bleeding, anemia, or bleeding disorder....	<input type="checkbox"/> Y <input type="checkbox"/> N	Seizures, epilepsy or neurological problem.....	<input type="checkbox"/> Y <input type="checkbox"/> N
Arthritis.....	<input type="checkbox"/> Y <input type="checkbox"/> N	History of an eating disorder (anorexia, bulimia).....	<input type="checkbox"/> Y <input type="checkbox"/> N
High blood pressure.....	<input type="checkbox"/> Y <input type="checkbox"/> N	Accident/Injury to face, mouth and/or teeth.....	<input type="checkbox"/> Y <input type="checkbox"/> N
Endocrine or thyroid problems.....	<input type="checkbox"/> Y <input type="checkbox"/> N	Frequent headaches, colds or sore throats.....	<input type="checkbox"/> Y <input type="checkbox"/> N
Kidney problems.....	<input type="checkbox"/> Y <input type="checkbox"/> N	Cardiovascular problem, <b>heart murmur</b> or defect.....	<input type="checkbox"/> Y <input type="checkbox"/> N
Diabetes.....	<input type="checkbox"/> Y <input type="checkbox"/> N	Any medication prior to dental treatment.....	<input type="checkbox"/> Y <input type="checkbox"/> N
Pneumonia, tuberculosis or lung disorder.....	<input type="checkbox"/> Y <input type="checkbox"/> N	Taking any medication? (prescription, non-prescription or herbal) .....	<input type="checkbox"/> Y <input type="checkbox"/> N

**Please List:**

**DENTAL HISTORY**

**NOW OR IN THE PAST HAVE YOU HAD:**

- Missing or extra permanent teeth?  Y  N
- Jaw clicking, locking or discomfort?  Y  N
- Root canal treated teeth?  Y  N
- Periodontal "gum" problems or treatment?  Y  N
- Abnormal swallowing pattern  Y  N
- History of speech problems?  Y  N
- Mouth breathing or snoring?  Y  N
- Tooth grinding or jaw clenching  Y  N
- Frequent canker sores or cold sores?  Y  N
- Prior orthodontic examination(s) or treatment?  Y  N
- Any relative with similar tooth or jaw relationship problems?  Y  N

**Is there any dental work that still needs to be completed?**  Y  N  ?    Date of Last Check-up? \_\_\_\_\_

What is your primary orthodontic concern? \_\_\_\_\_

Is there anything else we should be aware of to provide optimum orthodontic care for you? \_\_\_\_\_

\_\_\_\_\_

I have read and understand the above questions. I will not hold my orthodontist or any member of his 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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PERSONAL INFORMATION CONSENT:**

We are committed to protecting the privacy of our patients' personal information and to utilizing all personal information in a responsible and professional manner. As a requirement of the federal and provincial governing bodies we have privacy policies in place. If you would like further information on the privacy policies of this office please ask one of our staff and we would be happy to answer any questions you may have.

*I consent to the collection, use and disclosure of personal information as set out above.*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature