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CONFIDENTIAL

American Association of Orthodontists
MEDICAL DENTAL HISTORY FORM-ADULT

Date _____

Patient's Last Name _____ First _____ Middle _____

Birthdate _____ Age _____ Sex _____ SS# _____

Street Address _____ City _____

State _____ Zip _____ Home Phone _____ Cell Phone _____

Please circle best number to reach you at _____ Email Address _____

Employer _____ Position _____ Work Phone _____

Name of Dental Insurance Co. _____

Whom can we thank for referring you here? _____

Patient is: Single _____ Married _____ Widowed _____ Separated _____ Divorced _____

If married, fill out this section:

Spouse's Name _____ Birthdate _____ SS# _____

Spouse's Employer _____ Position _____ Work Phone _____

Dental Insurance? _____ Name of Insurance Co _____

Who is the Responsible Party? _____

Address if Different From Patient _____

Phone if Different From Patient _____ Work Phone _____

Patient's Dentist _____ Address/Phone _____

Patient's Physician _____ Address/Phone _____

Other Family Members Treated _____

Musical Instruments Played _____

Favorite Sports, Hobbies _____

In Case We Cannot Reach You:

Person to Contact _____ Phone No. _____

For the following questions circle **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.

MEDICAL HISTORY

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 conditions

Yes No dk/u Endocrine or thyroid problems

Yes no dk/u Kidney problems

Yes No dk/u Diabetes

Yes No dk/u Cancer or been treated for a tumor

Yes No dk/u Stomach ulcer or hyperacidity

Yes No dk/u Mononucleosis, tuberculosis, pneumonia

Yes No dk/u Problems of the immune system

Yes No dk/u Hepatitis, jaundice

Yes No dk/u AIDS or HIV positive

Yes No dk/u Sexually transmitted disease

Yes No dk/u Fainting spells, seizures

Yes No dk/u Mental or behavioral problems

Yes No dk/u Vision, hearing, taste or speech

Yes No dk/u Loss of weight, poor appetite

Yes No dk/u Anemia or bleeding

Yes No dk/u High or low blood pressure

Yes No dk/u Easily tired

