CONFIDENTIAL

Medical Dental History Form for Adult Patients

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_____

Primary phone for appointment reminders (_____) _____-_____ Alternative phone (_____) _____-_____

E-mail address(es)_____

Occupation_____ Employer_____

Do you prefer to receive appointment reminders by ☐ Email ☐ Text

CLOSEST RELATIVE/EMERGENCY CONTACT

Spouse or closest relative's name(s)_____

Title ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other _____ Relationship to patient:_____

Address *(if different than patient address)*_____

Home phone (_____) _____-_____ Cell phone (_____) _____-_____ Work phone(_____) _____-_____

DENTIST

Patient's Dentist _____

Address, City, State:_____

Last seen_____ Reason_____ Next appointment_____

Other dentist/dental specialists now being seen: Name_____

Address, City, State_____

Reason:_____

GENERAL INFORMATION

What concerns you about your teeth?_____

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_____

Home phone (_____) _____-_____ Cell phone (_____) _____-_____

E-mail address(es)_____

Social Security # _____ - _____ - _____ Employer:_____

DENTAL INSURANCE

Primary policy holder's full name_____ Birthdate_____

Social Security # _____ - _____ - _____ Relationship to patient_____

Address and phone *(if not listed above)*_____

Employer_____

Insurance Company_____ Group #_____ ID#_____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

PATIENT HEALTH INFORMATION

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation. For the following questions, mark yes, no, or don't know/understand (dk/u).

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

Medication_____ Taken for_____

Medication_____ Taken for_____

Medication_____ Taken for_____

Have you ever taken any medications to strengthen your bones? Please describe._____

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

Do you chew or smoke tobacco?_____

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

PATIENT HEALTH INFORMATION

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

Severe allergies_____

Unusual dental problems_____

Jaw size imbalance_____

Your answers are for office records only, and are confidential. A thorough medical 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 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?

☐yes ☐no ☐dk/u Has you ever taken intravenous biophosphonates such as Zometa (zolendromic acid, Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?

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

MEDICAL 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 thumb/finger 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 filings?
☐yes ☐no ☐dk/u Any serious trouble associated with previous dental treatment?
☐yes ☐no ☐dk/u Have you ever been diagnosed with gum disease?
☐yes ☐no ☐dk/u Have you ever had an orthodontic consultation or treatment before now?

Have you had allergies or reactions to any of the following:

☐yes ☐no ☐dk/u Local anesthetics (novocaine, lidocaine, xylocaine)
☐yes ☐no ☐dk/u Latex (gloves, balloons)
☐yes ☐no ☐dk/u Aspirin or Ibuprofen (Motrin, Advil)
☐yes ☐no ☐dk/u Penicillin
☐yes ☐no ☐dk/u Other Antibiotics
☐yes ☐no ☐dk/u Metals (jewelry, clothing snaps)
☐yes ☐no ☐dk/u Acrylics
☐yes ☐no ☐dk/u Orther Substances_____

RELEASE AND WAIVER

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_____

Assignment of Benefits: I hereby assign all dental and medical benefits to which I am entitled to Willow Bend Orthodontics. I hereby authorize and direct my insurance carrier(s) to issue payment directly to Willow Bend Orthodontics. I understand that I am responsible for any amount not covered by insurance. I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company necessary to process my claim. A photocopy of this assignment is to be considered as valid as the original.

Signature_____ Date_____

I authorize Willow Bend Orthodontics, PLLC or its service provider to contact me via calling, emailing, or texting to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing.

Signature_____ Date_____

I authorize the release of any information regarding any information regarding the dental history and/or treatment to Willow Bend Orthodontics for the purpose of verifying, evaluating, or treating the above mentioned patient.

Signature_____ Date_____

(office use only)

MEDICAL HISTORY UPDATES

Dentist Initial Review_____ Date_____

Changes_____

Patient Signature_____ Date_____

Dental Staff Signature_____ Date_____

Changes_____

Patient Signature_____ Date_____

Dental Staff Signature_____ Date_____

Changes_____

Patient Signature_____ Date_____

Dental Staff Signature_____ Date_____

