American Association of Orthodontists®

CONFIDENTIAL

Medical Dental History Form for Adult Patients

PATIENT

Date _____ Social Security # _____

Patient's last name _____ First name _____ Middle initial _____

Title ☐ Mr. ☐ Mrs. ☐ Miss ☐ Dr. ☐ Other I prefer to be called _____

Birth date _____ What sex were you assigned on your birth certificate? ☐ Male ☐ Female

What is your current gender identification? ☐ Male ☐ Female ☐ Other What are your preferred pronouns? _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home address _____ City, State, Zip code_____

Cell phone _____ Home phone _____ Work phone _____

E-mail address(es) _____

Occupation _____ Employer_____

CLOSEST RELATIVE

Spouse or closest relative's name(s) _____ Relationship to patient _____

Title ☐ Mr. ☐ Mrs. ☐ Miss ☐ Dr. Other Prefers to be called _____

Address (if different than patient address) _____

Cell phone _____ Home phone _____ Work phone _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____

Address _____ City, State, Zip _____

Cell phone _____ Home 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 _____ Address _____

Insurance company _____ Group # _____ ID # _____

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

Secondary policy holder's full name _____ Birthdate _____

Social Security #_____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID # _____

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

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MEDICAL INSURANCE

Policy holder's full name _____

Insurance company _____

DENTIST

Patient's Dentist _____ Address, City, State _____

Last seen _____ Reason_____ Next appointment _____

Other dentists/dental specialists now being seen: Name _____ City, State _____

Reason _____

PHYSICIAN

Patient's Physician _____ City, State _____

Last seen _____ Reason _____ Next appointment _____

Most recent physical exam _____

Other physicians/health care providers being seen now:

Name _____ City, State _____ Reason _____

Name _____ City, State _____ Reason _____

GENERAL INFORMATION

What concerns you about your teeth? _____

Who suggested that you might need orthodontic treatment?_____

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. _____

PATIENT HEALTH INFORMATION

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

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

Medication _____ Taken for _____ Medication _____ Taken for_____

Medication _____ Taken for _____ Medication _____ Taken for _____

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

Do you or have you ever had a substance abuse problem? _____

Do you currently suffer with, or have you suffered in the past with an eating disorder? _____

Have you chewed tobacco ☐ Yes ☐ No or smoked any substance or vaped? ☐ Yes ☐ No

If yes, what is the frequency? _____

Have you noticed any changes in your face or jaws? _____

Any other physical problems? _____

How often do you brush? _____ How often do you floss? _____

Are you pregnant? ☐ Yes ☐ No Are you trying to become pregnant? ☐ Yes ☐ No

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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

- ☐ ☐ ☐ Have you ever taken intravenous medication for bone disorders or cancer such as bisphosphonates as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate)?
- ☐ ☐ ☐ Have you ever taken oral medication for bone disorders such as bisphosphonates Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate)?
- ☐ ☐ ☐ Hereditary or developmental conditions?
- ☐ ☐ ☐ Bone fractures, or major injuries?
- ☐ ☐ ☐ Any injuries to face, head, neck?
- ☐ ☐ ☐ Arthritis or joint problems?
- ☐ ☐ ☐ Endocrine or thyroid problems?
- ☐ ☐ ☐ Diabetes or low sugar?
- ☐ ☐ ☐ Kidney problems?
- ☐ ☐ ☐ Cancer, tumor, radiation treatment or chemotherapy?
- ☐ ☐ ☐ Stomach ulcer, hyperacidity, acid reflux?
- ☐ ☐ ☐ Immune system problems?
- ☐ ☐ ☐ History of osteoporosis?
- ☐ ☐ ☐ Gonorrhea, syphilis, herpes, sexually transmitted diseases?
- ☐ ☐ ☐ AIDS or HIV positive?
- ☐ ☐ ☐ Hepatitis, jaundice or other liver problem?
- ☐ ☐ ☐ Polio, mononucleosis, tuberculosis, pneumonia?
- ☐ ☐ ☐ Seizures, fainting spells, neurologic problem?
- ☐ ☐ ☐ Mental health disturbance or depression?
- ☐ ☐ ☐ Vision, hearing, or speech problems?
- ☐ ☐ ☐ History of eating disorder (anorexia, bulimia)?
- ☐ ☐ ☐ Have you experienced any weight change in the past several months?
- ☐ ☐ ☐ High or low blood pressure?
- ☐ ☐ ☐ Excessive bleeding or bruising, anemia?
- ☐ ☐ ☐ Chest pain, shortness of breath, tire easily, swollen ankles?
- ☐ ☐ ☐ Heart defects, heart murmur, rheumatic heart disease?
- ☐ ☐ ☐ Angina, arteriosclerosis, stroke or heart attack?
- ☐ ☐ ☐ Skin disorder (other than common acne)?
- ☐ ☐ ☐ Do you eat a well-balanced diet?
- ☐ ☐ ☐ Frequent headaches or migraines?
- ☐ ☐ ☐ Frequent ear infections, colds, throat infections?
- ☐ ☐ ☐ Asthma, sinus problems, hayfever?
- ☐ ☐ ☐ Tonsil or adenoid condition?
- ☐ ☐ ☐ Do you frequently breathe through your mouth?

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

Yes No DK/U

- ☐ ☐ ☐ Latex (gloves, balloons)
- ☐ ☐ ☐ Metals (jewelry, clothing snaps)
- ☐ ☐ ☐ Acrylics
- ☐ ☐ ☐ Local anesthetics (novocaine, lidocaine, xylocaine)
- ☐ ☐ ☐ Aspirin
- ☐ ☐ ☐ Ibuprofen (Motrin, Advil)
- ☐ ☐ ☐ Penicillin
- ☐ ☐ ☐ Other antibiotics
- ☐ ☐ ☐ Plant pollens

DENTAL HISTORY

Now or in the past, have you had:

Yes No DK/U

- ☐ ☐ ☐ Permanent or extra (supernumerary) teeth removed?
- ☐ ☐ ☐ Supernumerary (extra) or congenitally missing teeth?
- ☐ ☐ ☐ Chipped or injured primary or permanent teeth?
- ☐ ☐ ☐ Any sensitive or sore teeth?
- ☐ ☐ ☐ Bleeding gums, bad taste or mouth odor?
- ☐ ☐ ☐ Jaw fractures, cysts, infections?
- ☐ ☐ ☐ Any teeth treated with root canals or pulpotomies?
- ☐ ☐ ☐ "Gum boils," frequent canker sores or cold sores?
- ☐ ☐ ☐ History of speech problems or speech therapy?
- ☐ ☐ ☐ Difficulty breathing through nose?
- ☐ ☐ ☐ Food impaction between the teeth?
- ☐ ☐ ☐ Mouth breathing habit or snoring at night?
- ☐ ☐ ☐ History of speech problems?
- ☐ ☐ ☐ Frequent oral habits (sucking finger, chewing pen, etc.)?
- ☐ ☐ ☐ Teeth causing irritation to lip, cheek or gums?
- ☐ ☐ ☐ Abnormal swallowing (tongue thrust)?
- ☐ ☐ ☐ Tooth grinding or clenching?
- ☐ ☐ ☐ Clicking, locking in jaw joints?
- ☐ ☐ ☐ Soreness in jaw muscles or face muscles?
- ☐ ☐ ☐ Ringing in ears, difficulty in chewing or opening jaw?
- ☐ ☐ ☐ Have you ever been treated for "TMJ" or "TMD" problems?
- ☐ ☐ ☐ Any broken or missing fillings?
- ☐ ☐ ☐ Any serious trouble associated with previous dental treatment?
- ☐ ☐ ☐ Have you ever been diagnosed with gum disease or pyorrhea?
- ☐ ☐ ☐ Have you ever had an orthodontic consultation ortreatment before now?

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FAMILY MEDICAL HISTORY

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

Bleeding disorders _____

Diabetes _____

Arthritis _____

Severe allergies _____

Unusual dental problems _____

Jaw size imbalance _____

Other family medical conditions? _____

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature _____ Date_____

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_____

MEDICAL HISTORY UPDATES OR CHANGES

Changes _____

Patient Signature _____ Date_____

Dental Staff Signature _____ Date_____

Changes _____

Patient Signature _____ Date_____

Dental Staff Signature _____ Date_____

Changes _____

Patient Signature _____ Date_____

Dental Staff Signature _____ Date_____

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