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orthomom

New Patient Health History – Adult

PATIENT

Date ___ /___ /___

First Name: _____ Last Name: _____ Middle Initial: _____ I prefer to be called: _____

Birth date: ___ /___ /___ Sex: ☐ Male ☐ Female

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

Home address: _____ City, State, Zip code: _____

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

Email address: _____

Occupation: _____ Employer: _____

CLOSEST RELATIVE

Spouse or closest relative name(s) _____

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

Address (if different than patient address) _____

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

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 dentists/dental specialists now being seen:

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 tooth 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 ( ) _____ - _____ Email addresses _____

Social Security # _____ Employer _____

DENTAL INSURANCE

Primary policy holder's full name _____ Birth date ___ /___ /___

Social Security _____ Relationship to patient _____

Address & phone (if not listed above) _____

Employer Address _____

Insurance company _____ Group # _____ ID# _____

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

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, please 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?
☐	☐	☐	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 problems?
☐	☐	☐	Polio, mononucleosis, tuberculosis, pneumonia?
☐	☐	☐	Seizures, fainting spells, neurologic problems?
☐	☐	☐	Mental health disturbance or depression?
☐	☐	☐	Vision, hearing, or speech problems?
☐	☐	☐	History of eating disorder (anorexia, bulimia)?
☐	☐	☐	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)?
☐	☐	☐	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 or the following?

Yes	No	DK/U	
☐	☐	☐	Local anesthesia (novocaine, lidocaine, xylocaine)
☐	☐	☐	Latex (gloves, balloons)
☐	☐	☐	Aspirin
☐	☐	☐	Metals (jewelry, clothing snaps)
☐	☐	☐	Pencilin
☐	☐	☐	Other antibiotics
☐	☐	☐	Ibuprofen (Motrin, Advil)
☐	☐	☐	Acrylics
☐	☐	☐	Plant pollens
☐	☐	☐	Animals _____
☐	☐	☐	Foods _____
☐	☐	☐	Other _____

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?
☐	☐	☐	Chipped or injuted 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?
☐	☐	☐	Difficult breathing through nose?
☐	☐	☐	Food impactions between the teeth?
☐	☐	☐	Mouth breathing habit or snoring at night?
☐	☐	☐	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 joint?
☐	☐	☐	Soreness in jaw muscles or face muscles?
☐	☐	☐	Ringing in ears, difficult chewing or opening jaw?
☐	☐	☐	Have you ever been treated for "TMJ" or "TMD" problems?
☐	☐	☐	Any broken or missing fillings?
☐	☐	☐	Any serious trouble with previous dental treatment?
☐	☐	☐	Ever been diagnosed with gum disease or pyorrhea?
☐	☐	☐	Have you ever had any orthodontic consultation or treatment before now?

PATIENT HEALTH INFORMATION

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? _____

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

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

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 ___ /___ /___