DAVID ORTHODONTICS

CONFIDENTIAL DATE: _____

MEDICAL DENTAL HISTORY FORM - ADULT

Last Name: _____ Legal First Name: _____
Birth date: (dd-mm-yy) _____ Preferred Name: _____
Mailing Address: _____
_____
Home Phone: _____ Business Phone: _____
Spouse / Partner Name: _____
Person To Contact in Emergency: _____
Whom may we thank for referring you to our clinic? _____
If you would like to receive automatic appointment reminders from our office, please provide your: e-mail address (print clearly) _____ Cell phone: _____

DENTAL INFORMATION

Dentist's Name: _____ Date of last check up: _____

For the following questions mark **yes, no or don't know (d/k)**.	yes	no	d/k
1. Has any family member had orthodontic treatment?	☐	☐	☐
2. Are you dissatisfied with the appearance of your teeth?	☐	☐	☐
3. Are you dissatisfied with the function of your teeth?	☐	☐	☐
4. Have you been informed of missing teeth or teeth that did not form?	☐	☐	☐
5. Do you have any speech problems?	☐	☐	☐
6. Have you experienced clicking of the jaw?	☐	☐	☐
7. Do you have pain in the jaw joint, ear or side of face?	☐	☐	☐
8. Have you experienced:			
a) Difficulty in opening and closing your mouth?	☐	☐	☐
b) Difficulty chewing?	☐	☐	☐
c) Frequent headaches?	☐	☐	☐
d) Head, neck, jaw or teeth injuries?	☐	☐	☐
9. Habits - Do you:			
a) Clench or grind your teeth?	☐	☐	☐
b) Bite your lips or cheeks frequently?	☐	☐	☐
c) Are you unable to breath through your nose?	☐	☐	☐
10. Have you had any of the following?			
a) Your teeth ground or your bite adjusted?	☐	☐	☐
b) A bite plate or any other oral appliance?	☐	☐	☐
c) Teeth extracted because of crowding?	☐	☐	☐
d) If **yes** to any of the above, please explain: _____			

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MEDICAL INFORMATION

Physician's Name: _____ Date of last physical exam: _____

For the following questions mark **yes, no or don't know (d/k)**

	yes	no	d/k
1. Have you ever been hospitalized for any operation or illness? If so, for what? _____	☐	☐	☐
2. Do you have (or had) any of the following diseases or problems:			
a) heart disease, rheumatic or scarlet fever, heart murmurs or heart valve replacements?	☐	☐	☐
b) hepatitis, jaundice, mononucleosis, or pneumonia?	☐	☐	☐
c) fainting spells, dizziness, or seizures?	☐	☐	☐
3. Do you wear contact lenses?	☐	☐	☐
4. Have you had radiation therapy for any disease of the head or neck?	☐	☐	☐
5. Does anyone in your family have any disability, birth defect, or growth related problem?	☐	☐	☐
6. Are you pregnant or do you think you might be?	☐	☐	☐
7. Do you smoke or use tobacco products?	☐	☐	
8. Are you allergic to latex, nickel, red food dye, aspirin, penicillin or any other drug? _____	☐	☐	☐
9. Do you take any medications for your bones? If yes, name: _____	☐	☐	☐
10. Do you have any disease, condition or problem not listed above that we should know about? _____	☐	☐	☐
11. Please list all the medications that you are currently taking. _____			
11. Are you currently under the care of a physician?	☐	☐	☐

Realizing that successful treatment greatly depends upon patient cooperation in following instructions, keeping appointments and maintaining oral hygiene, are there any restrictions, handicaps or problems that might be encountered during treatment?

_____

_____

If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: _____ Date Signed: _____