



MEDICAL DENTAL HISTORY- ADULT

Patient's Name: _____ Age: _____ Birth Date: _____

Male Female Phone Number: _____ Single Married

Home Address: _____ City: _____ Zip: _____

Email : _____ How did you hear about us? _____

Who suggested that you might need orthodontic treatment? _____

Dentist: _____ Phone Number: _____

Date of Last Dental Exam: _____ Reason: _____

Is the patient allergic to latex? _____ History of antibiotic prophylaxis for dental treatment? _____

Please check each box, yes or no, if you have ever had any illness or conditions listed below.

- Y N Arthritis Allergies Anemia Artificial Joint
Asthma Cancer Diabetes Dizzy Spells
Epilepsy Fainting Heart Murmur Hepatitis
Kidney Disease Liver Problems Lung Disease Nervous Disorder
Mental Disorder Sinus Trouble Stroke Tuberculosis
Tobacco Hospitalization Alcohol Recreational Drugs
Supernumerary (extra) teeth Jaw fractures, cysts or mouth infections
Periodontal "gum problems" Pain in jaw or ringing in ears
Congenitally missing teeth Family history of jaw size imbalance

Have you had any disease, serious illness/surgery, condition or problem not listed above? Y N

If yes, explain _____

Are you currently taking medications, nutrient supplements, herbal medications or non-prescription medicines?

Please name them. _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my orthodontist of any change in my health. I further certify that I consent to the performing of x-rays, oral examination, and pictures taken for office records.

Patient's Signature/Responsible Party

Date

For Doctor's Use Only

Health History Reviewed By _____ (Dr Signature) Date: _____

Notes:

