ADULT PATIENT INFORMATION AND HEALTH HISTORY

Welcome to our office. Please fill out both sides of form.

Patients Name _____ Age_____ Birthdate_____Sex _____

Address _____

Home Phone _____ Cell Phone _____

Employer _____ Business Phone _____

Occupation _____ E-mail _____

Marital Status _____

Person(s) responsible for financial matters

Name(s) _____ Name(s) _____

Address _____ Address _____

City,State _____ City,State _____

Home Phone _____ Home Phone _____

Business Phone _____ Business Phone _____

Place of Employment _____ Place of Employment _____

Social Security Number _____ Social Security Number _____

Are you covered by insurance for orthodontic treatment? ❑ No ❑ Yes

If yes, by which company? _____

	Family Dentist	Family Physician	Referred By
Name	_____	_____	_____
Address	_____	_____	_____
City, State	_____	_____	_____

Your interests and hobbies _____

Reason for orthodontic consultation? _____

Has anyone in your family had a similar problem? _____

Are you self-conscious about your teeth? _____

MEDICAL HISTORY – Have you ever had any of the following? (please circle)

AIDS	Bleeding	Emotional Problems	Hepatitis	Previous Surgery
Allergy	Bone Loss / Disorders	Epilepsy / Seizures	Herpes	Rheumatic Fever
Anemia	Cold Sores	Hearing Problems	Kidney Disease	Thyroid Problems
Arthritis	Diabetes	Heart Condition	Lung Disease	Other (describe below)
Asthma	Endocrine Problems	Head or Face Injuries	Oral Ulcer	

Comments _____

_____

_____

Have you been under the care of a physician during the past two years, other than for routine examinations? ❑ No ❑ Yes

Condition _____

_____

Date of last medical exam _____

Do you require antibiotic premedication for dental procedures? ❑ No ❑ Yes

Present drugs or medications _____

Birth Defects _____

Patient's Height _____ Patient's Weight _____

RESPIRATORY HISTORY

Do you:

1. Have allergies to: Drugs: _____ Food: _____

Seasonal Grasses: _____ Other: _____

2. Breathe through mouth?	Seldom	Sometimes	Usually
3. Snore when sleeping?	No	Yes	
4. Have frequent colds?	No	Yes	
5. Have frequent "Stuffy Nose"?	No	Yes	
6. Have frequent sore throat or tonsillitis?	No	Yes	
7. Have chewing or swallowing difficulty?	No	Yes	

Have you received medical treatment from an allergist or ear, nose and throat specialist? ❑ No ❑ Yes

If yes: When _____ By Whom _____

Nasal Surgery _____ Tonsils removed _____ Adenoids removed _____

DENTAL AND TEMPOROMANDIBULAR JOINT HISTORY

Have you had any unusual dental experiences? ❑ No ❑ Yes

Specify _____

Date of last dental checkup_____Were your teeth cleaned? ❑ No ❑ Yes

Have you had an orthodontic consult or treatment? ❑ No ❑ Yes

Do you have Headaches?____ Neck Pain?____ Jaw Pain?____ Ear Pain?____ Face Pain?____ Eye Pain?____ Other?____

Which side hurts? Right_____ Left_____ Both_____

How long have you had these symptoms? _____ years _____ days _____ months

Is the pain constant?_____ aching?____ shooting?____ burning?____ stabbing?____ electrical?____ other?____

Worse in the afternoon?____ Worse in the morning?____ Does it hurt to chew?____ Does it hurt to open wide?____

Does your jaw make a popping noise?_____ clicking?____ grinding?____ other?____

Has your jaw ever "locked" or slipped out of place? _____

Do you ever clench or grind your teeth?_____ During the day?____ During the night?____

Do you have problems with your ears?_____ Hearing?____ Dizziness?____ other?____

Is it difficult to swallow? _____ Painful? _____

Are your teeth sore or sensitive? _____

Additional comments _____

_____

_____

Signature_____ Date_____