O'Brien Orthodontics

Welcome!

Medical/Dental History Form
For Adults

Date ____________________

Patient's Full Name ____ Nickname ____________________

Date of Birth ____________________ Sex __________ Social Security Number ____________________

Address (street) ____

City ____________________ State ____________________ Zip Code ________________________

Home Phone ____________________ Cell Phone ____________________ E-mail ____________________

Employed By ____ Business Phone ____________________

Occupation ____

Spouse's Name ___________________________________ Social Security Number ____________________

Employed By ____ Business Phone ____________________

Marital Status: Married____ Divorced ____ Separated____ Widowed____ Single____

Current Dentist ___________________________________ Phone Number ____________________

Current Physician _________________________________ Phone Number ____________________

Do you have Orthodontic Insurance? Yes ___ No ___ If Yes, please complete the information below

Insurance Provider ____ Phone ____________________

Address ____

Member Name ____ Group # ____________________

Policy Holder's Date of Birth ____________________

Secondary Insurance Provider ____________________ Phone ______________ Group #______________

Policy Holder Name __________________________ Policy Holder's Date of Birth ______________

Whom may we thank for referring you to our office? ____

Patient's Hobbies or Interests ____

For the following questions circle yes, no, or don't know/understand (Dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

MEDICAL HISTORY

Yes No Dk/u Jaw fractures, any major accidents?
Yes No Dk/u Rheumatoid or arthritic conditions?
Yes No Dk/u Vision, hearing tasting or speech difficulties?
Yes No Dk/u Endocrine or thyroid problems
Yes No Dk/u Loss of weight recently, poor appetite?
Yes No Dk/u Excessive bleeding, black & blue tendency, anemia or bleeding disorder?
Yes No Dk/u High or low blood pressure?
Yes No Dk/u Cardiovascular problem (heart trouble) heart defect, coronary insufficiency?
Yes No Dk/u Problems of the immune system?
Yes No Dk/u AIDS or HIV positive?
Yes No Dk/u Tonsil or adenoid conditions?
Yes No Dk/u Mental health or behavioral problems?
Yes No Dk/u Endocrine or thyroid problems?
Yes No Dk/u Hayfever, asthma, sinus trouble?
Yes No Dk/u Diabetes?
Yes No Dk/u Stomach ulcer or hyperacidity?

Yes No Dk/u Fainting spells, seizures, epilepsy or neurologic problems?
Yes No Dk/u Frequent headaches, colds or sore throats?
Yes No Dk/u Allergic to latex?
Yes No Dk/u Allergies or drug reactions? ______________________
Yes No Dk/u Are you taking medication, nutrient supplements or non-prescription medicine? Please name them. ______________________
Yes No Dk/u Hospitalized for? ______________________
Yes No Dk/u Being treated by another health care professional for? ______________________
Date of most recent physical exam? ______________________
Yes No Dk/u Any medical concerns we should be aware of? ______________________
Female Patient - Are you currently, or anticipating becoming pregnant? ______________________

DENTAL HISTORY

Yes No Dk/u Teeth sensitive to hot or cold?
Yes No Dk/u Frequent canker sores or cold sores?
Yes No Dk/u Periodontal "Gum Problems"?
Yes No Dk/u Thumb sucking, finger habit , etc?
Yes No Dk/u Mouth breathing habit, snoring or difficulty in breathing?
Yes No Dk/u Tooth grinding, jaw clenching, clicking or locking?
Yes No Dk/u Any pain in jaw or ringing in the ears?
Yes No Dk/u Have you ever been treated for "TMJ" problems (Your jaw joint and facial muscle pain?)
Yes No Dk/u Do you experience any pain or soreness in the muscles of the face or around the ears?

Yes No Dk/u Has patient had any serious trouble associated with any previous dental treatment?
Yes No Dk/u Has patient ever had a prior orthodontic examination or treatment?
Yes No Dk/u Date of most recent dental exam? ______________________
Yes No Dk/u Has patient recently been under another dentist's care? Specialist ______________________
Yes No Dk/u What is your primary concern? Why are you here? ______________________
____

Yes No Dk/u Difficulty encountered in chewing or jaw opening?
Yes No Dk/u Concerned about spaced, crooked or protruding teeth?
Yes No Dk/u Aware or concerned about under or over developed jaw?
Yes No Dk/u Any relative with similar tooth or jaw relationships?
Yes No Dk/u Have any permanent teeth been removed?

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

I have read and understand the above questions. I will not hold my orthodontist or his staff responsible for any errors or omissions that I have made in completing this form. I will inform this practice of any changes.

______________________ ______________________
Signature Date

Member
American Association of Orthodontists