

Patient's Family Information, Medical, & Dental History (Adult)

(please complete in ink)

Today's Date _____

Name _____
First Last M.I. Nickname Age Sex Date of Birth

Address _____
Street City Zip Tel. # (____) _____

Employed by _____ Occupation _____ Position _____

Employer Address _____
Street City Zip Work Tel. # (____) _____

Best telephone number to call for appointments (During Business Hours) _____

Best Fax # _____ Best Cell Phone # _____ Best E-mail Address _____

Social Security Number of Patient (for accounting purposes only) _____

Marital Status: Single Married Separated Divorced Widowed Remarried Other

Husband/Wife Name _____
First Last M.I. Date of Birth _____

Social Security Number _____ (for insurance purposes only)

Employed by _____ Occupation _____ Position _____

Employer Address _____
Street City Zip Work Tel. # (____) _____

Cell. # (____) _____

Patient's Family Dentist _____
Name Address Tel. #

Patient's Family Physician _____
Name Address Tel. #

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

Do you have Orthodontic Insurance? _____ Yes _____ No Name of Insurance Company _____
(This may be different from Dental Insurance)

Do you have Medical Insurance? _____ Yes _____ No Name of Insurance Company _____

If responsible party is other than the patient, please give information:

Not Applicable

Name _____ S.S.# _____ Relationship to patient _____
(for insurance purposes only)

Address _____ Tel. # (_____) _____
Street City Zip

Does Responsible Party have Orthodontic Insurance? ____ Yes ____ No Name of Insurance Company _____
(This may be different from Dental Insurance)

Does Responsible Party have Medical Insurance? ____ Yes ____ No Name of Insurance Company _____

MEDICAL HISTORY

Have you had or do you have any of the following?

| | Yes | No | | Yes | No |
|----------------------|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Persistent Headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Neck Pains | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Nerve or Brain Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack/Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Migraine or Headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Vessel Disease | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Disorder | <input type="checkbox"/> | <input type="checkbox"/> | Mental Health Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS/HIV Infection | <input type="checkbox"/> | <input type="checkbox"/> | Bone Disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis (Any type) | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis (Any type) | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Sleep Apnea | <input type="checkbox"/> | <input type="checkbox"/> |
| Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | Ear Disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| Herpes (Any type) | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Infection | <input type="checkbox"/> | <input type="checkbox"/> |
| Psoriasis | <input type="checkbox"/> | <input type="checkbox"/> | Swollen Glands | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Allergies | <input type="checkbox"/> | <input type="checkbox"/> |

Comments _____

Please list any other significant information about your medical history: _____

- Yes No
- Are you under a physician's care at present? If yes, reason _____
- Are you presently, or have you ever been, under the care of a psychiatrist or psychologist?
If yes, describe _____
- Are you currently taking any medication? If yes, describe _____
- Are you allergic to any medications? (Eg: aspirin, penicillin, etc.) If yes, list _____
- Have you ever had any general anesthesia? When? _____
- Do you take vitamins? If yes, what type? _____
- Do you take calcium?

FEMALE PATIENTS

- Yes No
- Have you had or has anyone in your family had osteoporosis?
- Is there a possibility that you could be pregnant?

DENTAL HISTORY

Yes No

- Do any of your teeth hurt? If yes, upper right upper left lower right lower left
- Have any wisdom teeth been removed? How many? _____
- Have you ever had treatment for a periodontal disease (gum disease)? If yes, describe _____
- Have you ever had any previous orthodontic treatment (braces)? If yes, when _____
If yes, doctor's name and address _____

TMD HISTORY

Do you experience: Headaches Ear pain Face Pain Other _____

How long have you had the symptoms? _____

Is the pain: Constant Aching Burning Stabbing Other _____

Worse in the morning? Worse in the afternoon?

Do you experience: Pain in your ears Problems with hearing Dizziness Ringing or buzzing in ears

Describe your problem in your own words _____

Yes No

- Have there been any injuries to your mouth or teeth? If yes, describe _____
- Have you ever had any injury to your head or neck area? If yes, describe _____
- Have you ever fallen and bumped your chin, or received any trauma to your jaws? If yes, describe _____
- Have you ever had any surgery in the head and neck area? If yes, describe _____
- Do you clench or grind your teeth? If yes, while sleeping under stress other _____
- Are your teeth sore or sensitive?
- Do your jaw muscles ever feel tired? If yes, when _____
- Do you feel as though you are under a lot of stress?
- Do you ever notice soreness, tightness or pain in the muscles around the jaws or face? If yes, describe _____

- Does it hurt to chew or open wide? If yes, where does it hurt? _____
- Do you hear clicking (popping) or grating sounds in your jaw joints? If yes, please describe:
- | | Right | Left | Since when | During what activity |
|------------------------------------|--------------------------|--------------------------|------------|----------------------|
| <input type="checkbox"/> Clicking: | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| <input type="checkbox"/> Grating: | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
- Did these joint sounds begin gradually or suddenly? gradually suddenly
- Was there some specific event that started the joint sound or pain? If yes, describe _____
- Have you ever experienced difficulty in opening or closing your jaws? If yes, describe _____
- Have your jaws ever "locked" closed? If yes, describe _____

Yes No Have your jaws ever "locked" wide open? If yes, describe _____

Do you have pain in your jaw joints? If yes, right left Since when? _____

Did your pain start gradually or suddenly? gradually suddenly

During what activity? _____ Describe nature of pain _____

What increases the pain? _____ What decreases the pain? _____

Do you have any of the following habits?

| | | | | | |
|------------------------------|-----------------------------|---------------------------------|------------------------------|-----------------------------|---|
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Finger/Thumb sucking | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Caffienated Beverages (coffee, soda, tea) |
| <input type="checkbox"/> | <input type="checkbox"/> | Lip Biting | <input type="checkbox"/> | <input type="checkbox"/> | Do you exercise regularly? |
| <input type="checkbox"/> | <input type="checkbox"/> | Nail Biting | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Gum Chewing | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Ice Chewing | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Smoke or Smokeless Tobacco User | | | |

Please describe why you sought this consultation _____

Yes No Have you ever been treated for this problem before? If yes, please describe the diagnosis and treatment _____

Has any other member of the family had orthodontic treatment?

Has any other member of the family been a patient in this office?
Name(s) _____

We recognize that patients sometimes have specific concerns that may not be addressed by the questions in this Clinical History Form. Please feel free to include any other information regarding your clinical history, or any other concerns that you may have, in the space below. If necessary, please add another sheet of paper.

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to my clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

(Signature of Patient) _____ Date _____

Doctor's Notes _____

(Doctor's Signature) _____ Date _____