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Today's date ______________

ADULT HISTORY

Patient's Name ________________________ ___________ ________________________________ ________________
First / Middle Incial / Last / Date of Birth

Patient's Address ____ _____________________ ___________________
Home Phone / Cell Phone

Employer ____________________________Occupation_______________________ Business Phone ________________

Spouse's Name ____________________________Employer_______________________ Occupation ________________

Family Dentist ______________________________Address ____________________________Phone ________________

How did you hear about our office? Internet? __ Insurance?__ Referral? __ If so, whom? _________ Other? __ (Please check one)

Would you like to receive text text messages for appointment reminders? If so, please list up to 3 cell phone numbers to receive text messages:

____

INSURANCE

Is there insurance covering orthodontics?______ Name of insurance carrier _____________________________________

Phone # and address of insurance carrier____

Employer _____________________________ Group # _______________ Employee Name ______________________

Employee ID #___________________________ Employee Date of Birth _______________________________________

MEDICAL HISTORY

Present state of health: _____ Excellent _____ Good _____ Fair _____ Poor

Currently under physician's care? __ Yes __No Why? ____

Currently taking medication? __Yes __ No What? __________Are you currently taking medication for osteoporosis?___

Is there any history of:

_____ Speech problems
_____ Bleeding disorders
_____ Birth defects
_____ Facial injuries
_____ Facial operations
_____ Vision impairment
_____ Hearing problems
_____Tonsillitis
_____ Asthma, sinus trouble, hayfever
_____ Bone fractures/major accidents
_____ Rheumatoid or arthritic conditions
_____ Cancer, tumor, radiation, or chemotherapy
_____ Frequent headaches, colds, or sore throats
_____ Tonsil or adenoid conditions
_____ Cardiovascular problem (heart murmur, rheumatic heart disease, congenital heart defects, etc.)

Please explain any of the above positive responses: ____

Allergies or reactions to the following:

_____ Local anesthetics (novocaine or lidocaine)
_____ Aspirin
_____ Ibuprofen (Advil, Motrin)
_____ Penicillin or other antibiotics
_____ Latex (gloves)
_____ Vinyl
_____ Metals (jewelry, clothing snaps)
_____ Acrylic
_____ Other substances (specifiy)

Other Allergies? – Please list: ____

Serious Illness? Operations? ____

DENTAL HISTORY

Have you had: _____ Regular dental check-ups _____ X-rays _____ Impressions _____ Extractions

DENTAL and ORTHODONTIC INFORMATION

Now or in the past, have you had:

_____ Tooth grinding _____ Clenching _____ Mouth breathing _____ Tongue thrust

_____ Injury to teeth, face, or jaw _____ Teeth sensitive to hot, cold/toothache _____ Jaw fractures/cysts/infections

_____ Root canals or "dead" teeth _____ Periodontal "gum problems" _____ Ringing in ears

_____ Headaches _____ Pain/soreness in muscles of face _____ Difficulty chewing or opening jaw

_____ Jaw pain _____ Jaw clicking/popping/locking _____ Teeth irritating cheek, lip, tongue, or palate

_____ Frequent cold sores

_____ Ever had a prior orthodontic exam or treatment _____ Concerned about spaced, crooked, or protruding teeth

_____ Any relative with similar tooth or jaw relationships _____ Aware or concerned about under or over-developed jaw

Previous orthodontic treatment ? Self? ___ Yes ___ No Others in family? ___ Yes ___ No

If so, with what result? Self? ___ Excellent ___ Good ___ Poor Others in family: ___Excellent ___ Good ___Poor

What do you consider to be the main benefits of orthodontic correction?

___ Cosmetic ____ Functional ___ Psychological/ Emotional Other ____

Are you self-conscious of your teeth? _____ Yes _____ No

What is your primary concern? Why are you here? ____

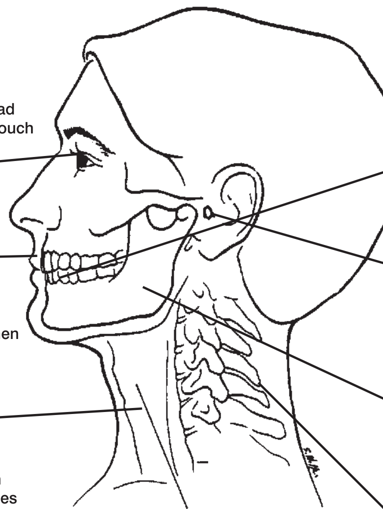
Circle any symptoms you have had in the past or currently have.

HEAD PAIN, HEADACHE
1. Forehead
2. Temples
3. 'Migraine' type
4. Sinus type
5. Shooting pain up back of head
6. Hair and/or scalp painful to touch

EYES
1. Pain behind eye
2. Bloodshot eyes
3. May bulge out
4. Sensitive to sunlight

MOUTH
1. Discomfort
2. Limited opening of mouth
3. Inability to open smoothly
4. Jaw deviates to one side when opening
5. Locks shut or open
6. Can't bite

THROAT
1. Swallowing difficulties
2. Laryngitis
3. Sore throat with no infection
4. Voice irregularities or changes
5. Frequent coughing or constant clearing of throat
6. Feeling of foreign object



TEETH
1. Clinching, grinding at night
2. Looseness and soreness of back teeth

EAR PROBLEMS
1. Hissing, buzzing or ringing
2. Decreased hearing
3. Ear pain, ear ache, no infection
4. Clogged "itchy" ears
5. Vertigo, dizziness

JAW PROBLEMS
1. Clicking, popping jaw joints
2. Grating sounds
3. Pain in cheek muscles
4. Uncontrollable jaw movements

NECK PROBLEMS
1. Lack of mobility, stiffness
2. Limited opening of mouth
3. Inability to open smoothly
4. Jaw deviates to one side when opening
5. Locks shut or open
6. Can't bite

I have read and understand the above questions. I will not hold my orthodontist or any member of his /her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed ____ Date signed _____________

Signed ____ Date signed _____________

Witness