MEDICAL DENTAL HISTORY FORM FOR ADULT PATIENTS

PATIENT INFORMATION

Patient Name: _____ ☐ Male ☐ Female

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Is Patient Financially Responsible for Patient's own Account? ☐ **YES** ☐ **NO**

Social Security # _____ Birth Date: _____ Age: _____

Cell #: _____ Home #: _____ Work #: _____

Email: _____

Address: _____
Street Apartment #

_____
City State Zip

Occupation: _____ Employer Name & Address: _____

CLOSEST RELATIVE

Full Name 1: _____ Birth Date: _____

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other _____ Relationship to Patient: _____

Is this person Financially Responsible for Patient's Account? ☐ **YES** ☐ **NO**

Occupation: _____ Employer Name & Address: _____

Social Security # _____

Cell #: _____ Home #: _____ Work #: _____

Email: _____

Address (if different from Patient): _____
Street Apartment #

_____
City State Zip

Full Name 2: _____ Birth Date: _____

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other _____ Relationship to Patient: _____

Is this person Financially Responsible for Patient's Account? ☐ **YES** ☐ **NO**

Occupation: _____ Employer Name & Address: _____

Social Security # _____

Cell #: _____ Home #: _____ Work #: _____

Email: _____

Address (if different from Patient): _____
Street Apartment #

_____
City State Zip

GENERAL INFORMATION

Does Patient play a musical instrument? _____

Have any other family members been treated at DFC Orthodontics? Please name them. _____

Child's Name: _____ Age: _____ Had Orthodontic Treatment? ☐ YES ☐ NO If Yes, where? _____

Child's Name: _____ Age: _____ Had Orthodontic Treatment? ☐ YES ☐ NO If Yes, where? _____

Child's Name: _____ Age: _____ Had Orthodontic Treatment? ☐ YES ☐ NO If Yes, where? _____

Child's Name: _____ Age: _____ Had Orthodontic Treatment? ☐ YES ☐ NO If Yes, where? _____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Newspaper ☐ School ☐ Work ☐ Other: _____

Name of person or office referring you to our practice: _____

DENTAL INSURANCE INFORMATION

Primary Policy Holder's Full Name: _____ Birth Date: _____

Social Security #: _____ Relationship to Pt: _____

Dental Ins Co: _____

Group # _____ ID # _____

Policy Holder's Employer: _____

Secondary Policy Holder's Full Name: _____ Birth Date: _____

Social Security #: _____ Relationship to Pt: _____

Dental Ins Co: _____

Group # _____ ID # _____

Policy Holder's Employer: _____

RELEASE AND WAIVER

1) I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis.
2) Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3) I agree to the use of topical anesthetics as necessary. I fully understand that using anesthetic agents embodies a certain risk.
4) I agree to be responsible for payment of all services on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a $25 late charge may be added to my account.
5) I hereby give DFC Orthodontics the absolute right and permission to use my photographs/slides for educational or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said photographs/slides.
6) I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature of Patient / Parent / Guardian	Print Name	Date

DENTAL HISTORY – ADULT PATIENT

Name of Dentist? _____ Dentist's Phone #: _____

Date of Last Cleaning/Examination: _____ How often do you have a Dental Cleaning/Examination? _____

1. Have you ever had orthodontic treatment or consult? ☐Yes ☐No If yes, when & where? _____
2. Have you ever seen a periodontist or been treated for gum disease? ☐Yes ☐No If yes, when & where? _____
3. Has your bite ever been adjusted? ☐Yes ☐No
4. Are your teeth sensitive? ☐Yes ☐No
5. Do/Did you suck your thumb? ☐Right ☐Left Does habit continue? ☐Yes ☐No *OR* What age did habit stop? _____
6. Do you ☐clench or ☐grind your teeth? If checked, do you do this: ☐All the time ☐Only at night ☐Only when nervous/stressed
7. Do your gums bleed? ☐Yes ☐No If yes, do gums bleed: ☐All the time ☐Occasionally
8. Have you noticed any mouth odors or bad tastes? ☐Yes ☐No
9. Does food tend to become caught between your teeth? ☐Yes ☐No
10. Do you have clicking or popping in your jaw? ☐Yes ☐No
11. Do you have difficulty opening or closing your mouth? ☐Yes ☐No
12. Have you been told you have a TMJ problem? ☐Yes ☐No
13. Do you get frequent headaches? ☐Yes ☐No
14. Would you like to keep your teeth all your life? ☐Yes ☐No
15. Have you noticed any loose teeth or change in your bite? ☐Yes ☐No If yes, please explain: _____
16. Have you ever had an injury to the face or teeth? ☐Yes ☐No If yes, please explain: _____
17. Do you feel nervous about having dental treatment? ☐Yes ☐No If yes, please explain: _____
18. Have you ever had an upsetting dental experience? ☐Yes ☐No If yes, please explain: _____
19. Have you had any complications following dental treatment? ☐Yes ☐No If yes, please explain: _____
20. Are you happy with the appearance of your teeth? ☐Yes ☐No If no, please explain: _____

MEDICAL INFORMATION – ADULT PATIENT

Name of Physician? _____ Physician's Phone #: _____

Have you ever had any of the following? Please check all that apply:

☐ AIDS	☐ Artificial Joints	☐ Excessive Bleeding	☐ Hepatitis	☐ Pre-Medication Required	☐ Stomach Problems
☐ Allergy to Latex	☐ Asthma	☐ Fainting	☐ High Blood Pressure	☐ Pregnancy	☐ Stroke
☐ Allergy to Nickel	☐ Blood Disease	☐ Glaucoma	☐ HIV	Due Date: _____	☐ Tuberculosis
☐ Allergy to Plastic	☐ Bone Disorders	☐ Growths/Cysts	☐ Jaundice	☐ Radiation Treatment	☐ Tumors
☐ Allergy to Codeine	☐ Cancer	☐ Hay Fever	☐ Kidney Disorders	☐ Respiratory Problems	☐ Ulcers
☐ Allergy to Penicillin	☐ Diabetes	☐ Head Injuries	☐ Liver Disease	☐ Rheumatic Fever	☐ Venereal Disease
☐ Anemia	☐ Dizziness	☐ Heart Disease	☐ Mental Disorders	☐ Rheumatism	☐ _____
☐ Arthritis	☐ Epilepsy	☐ Heart Murmur	☐ Pacemaker	☐ Sinus Problems	☐ _____

Please List All Medications: _____

1. Have you ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer? ☐Yes ☐No
2. Have you ever taken oral bisphosphonates such as Fosamax (aledronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders? ☐Yes ☐No
3. Have you ever been admitted to a hospital or needed emergency care during the past two years? ☐Yes ☐No If yes, please explain: _____
4. Are you now under the care of a physician? ☐Yes ☐No If yes, please explain: _____
5. Do you have any health problems that need further clarification? ☐Yes ☐No If yes, please explain: _____

I have read the above questions and understand them. 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. I will notify orthodontist of any change in my medical or dental health.

Signature of Patient / Parent / Guardian | Print Name | Date