MEDICAL & DENTAL HISTORY OF ADULT

Today's Date: _____

Patient's Name: _____

Date of Birth: _____ Age: _____ Years _____ Months _____

Male: _____ Female: _____ Social Security Number: _____

Address: Street _____

City _____ Zip Code _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

E-Mail Address: _____

Martial Status _____

Your Employer _____ Position _____

Work Phone ( ) _____

If applicable: Spouse's Name _____

Social Security Number: _____

Spouse's Employer: _____ Position: _____

Date of Birth: _____ Work Phone: ( ) _____

Person Responsible for Financial Matters:

Address and Phone (if Different from above):

Street _____

City _____ Zip Code _____

Does the Patient have Orthodontic Insurance Coverage? YES NO

If yes, which company? _____

Who is the Policyholder? _____

From whom were you referred so that we may send a thank-you? _____

If our office needs to contact you by phone, at which number is most convenient to reach you?

( ) _____ ( ) _____ ( ) _____

Home Office Other - Please Indicate

DENTAL HISTORY

Family Dentist: _____

Date of last dental exam: _____

How many times each day do you brush your teeth?

Have you ever had any injury or trauma to your face, teeth, or gums? YES NO

If yes, please explain: _____

Have you ever had an unfavorable dental experience? YES NO

If yes, please explain: _____

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Have you ever or do you currently (please circle if applicable):
Grind Teeth at Night Bite Fingernails Suck Thumb or Finger

If yes, when did you discontinue? _____
Do you have any trouble with your jaw joints? YES NO
If yes, please explain: _____

MEDICAL HISTORY

Family Physician: _____
Date of last physical exam: _____
Are you currently taking **ANY** medications? YES NO
If yes, please explains: _____
Are you allergic to any medication? YES NO
If yes, please list: _____

Has the patient ever had any of the following:

_____ AIDS or HIV	_____ Diabetes
_____ Anemia	_____ Epilepsy/Seizures
_____ Arthritis	_____ Hearing Problem
_____ Artificial Joint or Valve	Heart Murmur (Medicated?)
_____ Asthma	_____ YES NO
_____ Allergies (Please list) _____	
_____ Cancer	_____ Hepatitis
_____ Cerebral Palsy	_____ Kidney Disease
_____ Cold Sores	_____ Lung Disease
_____ Rheumatic Fever	_____ Tuberculosis
_____ Venereal Disease	
_____ Other (Please specify) _____	

Have you ever taken an antibiotic before a dental procedure? YES NO
If yes, please explain: _____

FEMALE PATIENTS ONLY:
Is there a possibility that the patient may be pregnant? YES NO

Are you currently taking, or have you taken Bisphosphonate medications (Fosomax, Didronel, or Boniva) for osteoporosis? YES NO