Medical Dental History Form for Adult Patients

PATIENT

Date _______________

Patient's last name ______________________________________ First name _____________________________________

Title: ☐ Mr. ☐ Mrs. ☐Ms. ☐Miss. ☐ Dr. I Prefer to be called ______________________________

Birth date ___________________ Sex: ☐Male ☐Female

Home address ____ City, State, Zip code ______________________________

Cell phone ( ) ________-_____________ Work phone ( ) ________-____________

Email Address____ Occupation _____________________________________

DENTIST

Patient's Dentist _________________________________ Address____

Month of Last Visit __________________ Reason _________________________________ Next appointment ______________

PHYSICIAN

Patient's Physician_______________________________ City, State____

Last seen____ Reason ____

Other physicians/health care providers being seen now: Name____

Reason ____

GENERAL INFORMATION

Are you interested in Invisalign Treatment? ☐YES ☐ NO ☐NOT SURE

What concerns you about your teeth? ____

Who suggested that your child might need orthodontic treatment? ____

Why did you select our office? ____

Describe any previous orthodontic treatment or consultations: ____

____

Have any other family members been treated in this office? Please name them ______________________________________

Do you have any pending fillings, crowns or dental work with your dentist? YES NO, If yes please list:___________________

____

FINANCIAL RESPONSIBILITY

Who is financially responsible for your account? ____

Address (if different than above)_______________________________________ City, State ______________________________

Cell Phone ( ) _______ - ____________

DENTAL INSURANCE (if there are two policies, the older by birth date is the primary)

Primary policy holder's full name ________________________ Birth date_____________ Social Security # _______________

Address (if not listed above) ____________________________ Employer____

Insurance company___________________________ Group # ______________________ ID# ___________________________

Does this policy have orthodontic benefits? ☐Yes ☐No ☐Don't Know

Secondary policy holder's full name _______________________ Birth date_____________ Social Security # ______________

Address (if not listed above) ____________________________ Employer____

Insurance company___________________________ Group # ______________________ ID# ___________________________

Does this policy have orthodontic benefits? ☐Yes ☐No ☐Don't Know

DENTAL HISTORY (Have you now or in the past had any of the following? please circle)

Dental Implants	YES	NO
Extra or congenitally missing teeth	YES	NO
Any teeth treated with root canals	YES	NO
Mouth breathing habit or snoring at night	YES	NO
Oral habits (sucking finger, chewing pens)	YES	NO
Clicking, locking in jaw joints	YES	NO
Treated for “TMJ” or “TMD” problems	YES	NO
Periodontal Disease or deep cleanings	YES	NO
Any sensitive or sore teeth	YES	NO
Frequent canker sores or cold sores	YES	NO
Use of CPAP or sleep apnea device	YES	NO
Tooth grinding or clenching	YES	NO
Soreness in jaw muscles or face muscles	YES	NO

Any serious trouble associated with previous dental treatment YES NO, if Yes please explain: ________________________

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MEDICAL HISTORY (Have you now or in the past had any of the following? please circle)

Birth defects or hereditary problems	YES	NO
Arthritis or joint problems	YES	NO
Cancer, tumor, or chemotherapy	YES	NO
Diabetes or low sugar	YES	NO
Seizures, fainting, or neurologic problems	YES	NO
Mental health disturbance or depression	YES	NO
Excessive bleeding or bruising, anemia	YES	NO
Asthma or sinus problems	YES	NO
Any injuries to face, head, neck	YES	NO
History of osteoporosis or bone problems	YES	NO
Endocrine or thyroid problems	YES	NO
Immune system problems	YES	NO
Taken Rx of bisphosphonates	YES	NO
Frequent headaches or migraines	YES	NO
Heart defects, heart murmur	YES	NO
Frequently breathe through mouth	YES	NO
Allergy to Latex?	YES	NO

Any Allergies YES NO, If yes please list:____

List any medication, nutritional supplements, herbal medications or non-prescription medicines that you take:

Medication____ Taken for ____

Medication____ Taken for ____

Medication____ Taken for ____

Have you ever taken any medications to strengthen your bones? If yes, Please describe.______________________________

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Do you require an antibiotic pre-medication before dental procedures? YES NO

Do you use tobacco products? YES NO Women: Are you pregnant? YES NO

Please provide any additional information you feel may be helpful in you diagnosis and treatment:

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RELEASE AND WAIVER

Dr. Sullivan has my permission to obtain diagnostic materials he deems necessary for orthodontic evaluation. I also authorize him to provide other health care providers with information regarding my orthodontic care if considered appropriate. I also understand it is my responsibility to keep Sullivan Orthodontics informed of any change in my medical or dental health status.

Patient Signature ____ Date ____________________