NORTH ATTLEBORO ORTHODONTICS
a myOrthos partner

Medical Dental History Form For Adult Patient

PATIENT

Date _____
Patient's Last name _____ First name _____Middle initial____
Birth date _____ Sex: ☐Male ☐ Female I prefer to be called _____
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Home address _____ City, State, Zip code _____
Home phone_____ Cell phone_____
E-mail address_____
Occupation _____ Employer _____

CLOSEST RELATIVE

Spouse or closest relative's name_____
Address (if different than patient address) _____
Home phone_____ Cell phone_____ Work phone_____

DENTIST

Patient's Dentist _____ Address, City, State _____
Last seen _____ Reason _____ Next appointment _____
Other dentists/dental specialists now being seen: Name _____ City, State _____
Reason _____

GENERAL INFORMATION

What concerns you about your teeth? _____
Who suggested that you might need orthodontic treatment? _____
Why did you select our office? _____
Have you had any previous orthodontic treatment? Please describe _____
Have any other family members been treated in this office? Please name them. _____

DENTAL INSURANCE

Primary policy holder's full name _____ Birthdate _____
Social Security # _ _ _ Relationship to patient _____
Address and phone (if not listed above) _____
Employer _____ Insurance company _____
Group # _____ ID # _____

PATIENT HEALTH INFORMATION

List any medication, nutritional supplements or non-prescription medicines, including fluoride supplements that you take.
_____
Have you ever taken any medications to strengthen your bones? Please describe. _____
Do you take antibiotic pre-medication before any dental procedures? ☐Yes ☐No
Do you or have you ever had a substance abuse problem? _____
Do you chew or smoke tobacco? _____
Any other physical problems? _____
How often do you brush? _____
How often do you floss? _____
Women: Are you pregnant? ☐Yes ☐No Are you trying to become pregnant? ☐Yes ☐No

Your answers are for office records only, and are confidential. A thorough medial history is essential to a complete orthodontic evaluation. For the following questions mark yes or no.

MEDICAL HISTORY

Now or in the past, have you had:

☐**YES** ☐**NO** Birth defects or hereditary problems?
☐**YES** ☐**NO** Bone fractures, or major injuries?
☐**YES** ☐**NO** Any injuries to face, head, neck?
☐**YES** ☐**NO** Arthritis or joint problems?
☐**YES** ☐**NO** Endocrine or thyroid problems?
☐**YES** ☐**NO** Diabetes or low sugar?
☐**YES** ☐**NO** Kidney problems?
☐**YES** ☐**NO** Cancer, tumor, radiation or chemotherapy?
☐**YES** ☐**NO** Stomach ulcer, hyperacidity, acid reflux?
☐**YES** ☐**NO** Immune system problems?
☐**YES** ☐**NO** History of osteoporosis?
☐**YES** ☐**NO** Gonorrhea, syphilis, herpes?
☐**YES** ☐**NO** AIDS or HIV positive?
☐**YES** ☐**NO** Hepatitis, jaundice or other liver problem?
☐**YES** ☐**NO** Polio, mononucleosis, tuberculosis, pneumonia?
☐**YES** ☐**NO** Seizures, fainting spells, neurologic problem?
☐**YES** ☐**NO** Mental health disturbance or depression?
☐**YES** ☐**NO** Vision, hearing, or speech problems?
☐**YES** ☐**NO** History of anorexia, bulimia?
☐**YES** ☐**NO** High or low blood pressure?
☐**YES** ☐**NO** Excessive bleeding or bruising, anemia?
☐**YES** ☐**NO** Frequent headaches or migraines?
☐**YES** ☐**NO** Do you eat a well-balanced diet?
☐**YES** ☐**NO** Skin disorder
☐**YES** ☐**NO** Tonsil or adenoid condition?
☐**YES** ☐**NO** Heart defects, heart murmur, rheumatic heart disease?
☐**YES** ☐**NO** Chest pain, shortness of breath, tire easily, swollen ankles?
☐**YES** ☐**NO** Frequent ear infections, colds, throat infections?
☐**YES** ☐**NO** Tonsil or adenoid condition? Angina, arteriosclerosis, stroke or heart attack?
☐**YES** ☐**NO** Do you frequently breathe through your mouth?

Please list any known allergies:_____

DENTAL HISTORY

Now or in the past, have you had:

☐**YES** ☐**NO** Permanent or extra teeth removed?
☐**YES** ☐**NO** Supernumerary or congenitally missing teeth?
☐**YES** ☐**NO** Chipped or injured primary or permanent teeth?
☐**YES** ☐**NO** Any sensitive or sore teeth?
☐**YES** ☐**NO** Bleeding gums, bad taste or mouth odor?
☐**YES** ☐**NO** Jaw fractures, cysts, infections?
☐**YES** ☐**NO** Any teeth treated with root canals or pulpotomies?
☐**YES** ☐**NO** "Gum boils," frequent canker sores or cold sores?
☐**YES** ☐**NO** History of speech problems or speech therapy?
☐**YES** ☐**NO** Difficulty breathing through nose?
☐**YES** ☐**NO** Food impaction between the teeth?
☐**YES** ☐**NO** Mouth breathing habit or snoring at night?
☐**YES** ☐**NO** History of speech problems?
☐**YES** ☐**NO** Frequent oral habits
☐**YES** ☐**NO** Teeth causing irritation to lip, cheek or gums?
☐**YES** ☐**NO** Abnormal swallowing (tongue thrust)?
☐**YES** ☐**NO** Tooth grinding or clenching?
☐**YES** ☐**NO** Clicking, locking in jaw joints?
☐**YES** ☐**NO** Soreness in jaw muscles or face muscles?
☐**YES** ☐**NO** Ringing in ears, difficulty in chewing or opening jaw?
☐**YES** ☐**NO** Have you ever been treated for "TMJ" or "TMD"?
☐**YES** ☐**NO** Any broken or missing fillings?
☐**YES** ☐**NO** Have you ever been diagnosed with gum disease?
☐**YES** ☐**NO** Have you ever had previous orthodontic treatment?

FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders _____
Diabetes _____
Arthritis _____
Unusual dental problems _____
Jaw size imbalance _____
Other family medical conditions? _____

RELEASE AND WAIVER

I have read the above questions and understand them. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature:_____ **Date:**_____
Dentist Signature:_____ **Date:**_____