American Association of Orthodontists®

CONFIDENTIAL

Medical Dental History Form for Adult Patients

PATIENT

Date _____

Patient's last name _____ First name _____ Middle initial_____

Title ☐ Mr. ☐ Mrs. ☐ Miss ☐ Dr. ☐ Other I prefer to be called_____

Birth date _____ Social Security # _____

What sex were you assigned on your birth certificate? ☐ Male ☐ Female

What is your current gender identification? ☐ Male ☐ Female ☐ Other

What are your preferred pronouns? _____

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

Home address _____ City, State, Zip code_____

Cell phone _____ Home phone _____ Work phone _____

E-mail address(es) _____

Occupation _____ Employer_____

CLOSEST RELATIVE

Spouse or closest relative's name(s) _____ Relationship to patient _____

Title ☐ Mr. ☐ Mrs. ☐ Miss ☐ Dr. Other Prefers to be called _____

Address (*if different than patient address*) _____

Cell phone _____ Home 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 _____

PHYSICIAN

Patient's Physician _____ City, State _____

Last seen _____ Reason _____ Next appointment _____

Most recent physical exam _____

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. _____

Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain. _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____

Address (*if different from page 1*) _____ City, State, Zip _____

Cell phone _____ Home phone _____

E-mail address(es) _____

Social Security #_____ Employer _____

DENTAL INSURANCE

Primary policy holder's full name _____ Birthdate _____

Social Security # _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID # _____

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

Secondary policy holder's full name _____ Birthdate _____

Social Security #_____ Relationship to patient _____

Address and phone (*if not listed above*) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID # _____

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

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation. For the following questions mark yes, no, or don't know/understand (dk/u).

MEDICAL HISTORY (Complete to the best of your ability)

Now or in the past, have you had:

Yes	No	DK/U	
☐	☐	☐	Have you ever taken intravenous medication for bone disorders or cancer such as bisphosphonates as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate)?
☐	☐	☐	Have you ever taken oral medication for bone disorders such as bisphosphonates Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate)
☐	☐	☐	Hereditary or developmental conditions?
☐	☐	☐	Bone fractures, or major injuries?
☐	☐	☐	Any injuries to face, head, neck?
☐	☐	☐	Arthritis or joint problems?
☐	☐	☐	Endocrine or thyroid problems?
☐	☐	☐	Diabetes or low sugar?
☐	☐	☐	Kidney problems?
☐	☐	☐	Cancer, tumor, radiation treatment or chemotherapy?
☐	☐	☐	Stomach ulcer, hyperacidity, acid reflux?
☐	☐	☐	Immune system problems?
☐	☐	☐	History of osteoporosis?
☐	☐	☐	Hepatitis, jaundice or other liver problem?
☐	☐	☐	Polio, mononucleosis, tuberculosis, pneumonia?
☐	☐	☐	Seizures, fainting spells, neurologic problem?
☐	☐	☐	Mental health disturbance or depression?
☐	☐	☐	Vision, hearing, or speech problems?
☐	☐	☐	History of eating disorder (anorexia, bulimia)?
☐	☐	☐	Have you experienced any weight change in the past several months?
☐	☐	☐	High or low blood pressure?
☐	☐	☐	Excessive bleeding or bruising, anemia?
☐	☐	☐	Chest pain, shortness of breath, tire easily, swollen ankles?
☐	☐	☐	Heart defects, heart murmur, rheumatic heart disease?
☐	☐	☐	Angina, arteriosclerosis, stroke or heart attack?
☐	☐	☐	Skin disorder (other than common acne)?
☐	☐	☐	Do you eat a well-balanced diet?
☐	☐	☐	Frequent headaches or migraines?
☐	☐	☐	Frequent ear infections, colds, throat infections?
☐	☐	☐	Asthma, sinus problems, hayfever?
☐	☐	☐	Tonsil or adenoid condition?
☐	☐	☐	Do you frequently breathe through your mouth?

Have you had allergies or reactions to any of the following:

Yes	No	DK/U	
☐	☐	☐	Latex (gloves, balloons)
☐	☐	☐	Metals (jewelry, clothing snaps)
☐	☐	☐	Acrylics
☐	☐	☐	Local anesthetics (novocaine, lidocaine, xylocaine)
☐	☐	☐	Aspirin
☐	☐	☐	Ibuprofen (Motrin, Advil)
☐	☐	☐	Penicillin
☐	☐	☐	Other antibiotics

DENTAL HISTORY

Now or in the past, have you had:

Yes	No	DK/U	
☐	☐	☐	Permanent or extra (supernumerary) teeth removed?
☐	☐	☐	Supernumerary (extra) or congenitally missing teeth?
☐	☐	☐	Chipped or injured primary or permanent teeth?
☐	☐	☐	Any sensitive or sore teeth?
☐	☐	☐	Bleeding gums, bad taste or mouth odor?
☐	☐	☐	Jaw fractures, cysts, infections?
☐	☐	☐	Any teeth treated with root canals?
☐	☐	☐	Frequent canker sores or cold sores?
☐	☐	☐	History of speech problems or speech therapy?
☐	☐	☐	Difficulty breathing through nose?
☐	☐	☐	Food impaction between teeth?
☐	☐	☐	Mouth breathing habit or snoring at night?
☐	☐	☐	History of speech problems?
☐	☐	☐	Frequent oral habits (sucking finger, chewing pen, etc.)?
☐	☐	☐	Teeth causing irritation to lip, cheek or gums?
☐	☐	☐	Abnormal swallowing (tongue thrust)?
☐	☐	☐	Tooth grinding or clenching?
☐	☐	☐	Clicking, locking in jaw joints?
☐	☐	☐	Soreness in jaw muscles or face muscles?
☐	☐	☐	Ringing in ears, difficulty in chewing or opening jaw?
☐	☐	☐	Have you ever been treated for "TMJ" or "TMD" problems?
☐	☐	☐	Any broken or missing fillings?
☐	☐	☐	Any serious trouble associated with previous dental treatment?
☐	☐	☐	Have you ever been diagnosed with gum disease?
☐	☐	☐	Have you ever had an orthodontic consultation or treatment before now?

PATIENT HEALTH INFORMATION

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

Do you take antibiotic pre-medication before any dental procedures? ☐ Yes ☐ No

Medication _____ Taken for _____ Medication _____ Taken for_____

Medication _____ Taken for _____ Medication _____ Taken for _____

Have you ever taken any medications to strengthen your bones? Please describe. _____

Do you currently suffer with, or have you suffered in the past with an eating disorder? _____

Have you chewed tobacco ☐ Yes ☐ No or smoked any substance or vaped? ☐ Yes ☐ No

If yes, what is the frequency? _____

Have you noticed any changes in your face or jaws? _____

Any other physical problems? _____

How often do you brush? _____ How often do you floss? _____

Are you pregnant? ☐ Yes ☐ No ☐ ☐

FAMILY MEDICAL HISTORY (Optional)

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

Bleeding disorders _____

Diabetes _____

Arthritis _____

Severe allergies _____

Unusual dental problems _____

Jaw size imbalance _____

Other family medical conditions? _____

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature _____ Date_____

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 my orthodontist of any changes in my medical or dental health.

Signature _____ Date_____

MEDICAL HISTORY UPDATES OR CHANGES

Changes _____

Patient Signature _____ Date_____

Dental Staff Signature _____ Date_____

Changes _____

Patient Signature _____ Date_____

Dental Staff Signature _____ Date_____

Changes _____

Patient Signature _____ Date_____

Dental Staff Signature _____ Date_____