BRACESETTERS

MEDICAL DENTAL HISTORY FORM FOR ADULTS

Date _____ Doctor_____ Office_____

Patient's Last Name: _____ First Name: _____ M. I.: _____

Birth Date: _____ Age: _____ Sex: Male □ Female □ I prefer to be called: _____

Social Security No.: _____ Home Telephone No.: _____

Cell Phone Number: _____ Pager Number: _____

Patient's Address:_____

City:_____ State: _____ Zip Code: _____

Patient is: □ Single □ Married □ Widowed □ Separated □ Divorced

Occupation: _____ Employer: _____ Years with Employer:_____

Business Address: _____ State: _____ Zip:_____Business Telephone No.:_____

Name of Spouse/Closest Relative: _____ Telephone No.(if different than yours):_____

Relationship to you:_____

Address (if different than yours):_____ City:_____ State: _____ Zip: _____

Name of Patient's Dentist: _____ Telephone No.: _____

Dentist's Address: _____City:_____State: _____ Zip Code: _____

Date Last Seen By Dentist: _____ Reason: _____

Name of Patient's Physician: _____ Telephone No.: _____

Physicians Address: _____City: _____ State: _____ Zip Code: _____

Date Last Seen By Physician: _____ Reason: _____

Who suggested that you might need orthodontic treatment? _____

Why did you select our office?_____

Who is Financially Responsible for this Account?

Last Name: _____ First Name: _____ M.I. _____

Address (if different from patient's) _____

City: _____ State: _____ Zip Code: _____ Yrs. at this Address _____

Telephone No. (if different from Patient's) _____ Social Security No.: _____

Employer: _____How many years? _____ Employer's address:_____

City:_____ State:_____ Zip:_____

Insurance coverage for dental treatment? Yes □ No □

Insurance coverage for orthodontic treatment? Yes □ No □

Primary Policy Holder's Name: _____ Social Security No.: _____

Birth Date: _____ Employed by: _____

Dental Insurance Company: _____ Group No.: _____

Secondary Policy Holder's Name: _____ Social Security No.: _____

Birth Date: _____ Employed by: _____

Dental Insurance Company: _____ Group No.:_____

For the following questions mark yes, no or don't know (dk). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

MEDICAL HISTORY

Now or in the past have you had:

- □ Yes □ No □ dk Birth defects or hereditary problems?
- □ Yes □ No □ dk Bone fractures, any major accidents?
- □ Yes □ No □ dk Rheumatoid or arthritic conditions?
- □ Yes □ No □ dk Endocrine or thyroid problems?
- □ Yes □ No □ dk Kidney problems?
- □ Yes □ No □ dk Diabetes?
- □ Yes □ No □ dk Cancer, tumor, radiation treatment or chemotherapy?
- □ Yes □ No □ dk Stomach ulcer or hyperacidity?
- □ Yes □ No □ dk Polio, mononucleosis, tuberculosis, pneumonia?
- □ Yes □ No □ dk Problems of the immune system?
- □ Yes □ No □ dk AIDS or HIV positive?
- □ Yes □ No □ dk Hepatitis, jaundice or liver problem?
- □ Yes □ No □ dk Fainting spells, seizures, epilepsy or neurological problem?
- □ Yes □ No □ dk Mental health disturbance or depression?
- □ Yes □ No □ dk Vision, hearing, tasting or speech difficulties?
- □ Yes □ No □ dk Loss of weight recently, poor appetite?
- □ Yes □ No □ dk History of eating disorder (anorexia, bulimia)?
- □ Yes □ No □ dk Excessive bleeding or bruising tendency, anemia or bleeding disorder?
- □ Yes □ No □ dk High or low blood pressure?
- □ Yes □ No □ dk Tired easily?
- □ Yes □ No □ dk Chest pain, shortness of breath or swelling of ankles?
- □ Yes □ No □ dk Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
- □ Yes □ No □ dk Osteoporosis?

Now or in the past have you had:

- □ Yes □ No □ dk Skin disorder?
- □ Yes □ No □ dk Tonsil or adenoid conditions?
- □ Yes □ No □ dk Frequent headaches, colds or sore throats?
- □ Yes □ No □ dk Eye, ear, nose or throat condition?
- □ Yes □ No □ dk Hayfever, asthma, sinus trouble or hives?
- □ Yes □ No □ dk Do you eat a well balanced diet?

Allergies or reactions to any of the following:

- □ Yes □ No □ dk Local anesthetics (Novocaine or Lidocaine)
- □ Yes □ No □ dk Aspirin
- □ Yes □ No □ dk Ibuprofen (Motrin, Advil)
- □ Yes □ No □ dk Penicillin or other antibiotics
- □ Yes □ No □ dk Sulfa drugs
- □ Yes □ No □ dk Codeine or other narcotics
- □ Yes □ No □ dk Metals (jewelry, clothing snaps)
- □ Yes □ No □ dk Latex (gloves, balloons)
- □ Yes □ No □ dk Vinyl
- □ Yes □ No □ dk Acrylic
- □ Yes □ No □ dk Animals
- □ Yes □ No □ dk Foods (specify) _____
- □ Yes □ No □ dk Other substances (specify) _____

□ Yes □ No □ dk Are you taking medication, nutrient supplements, herbal medications or non-prescription medicine. Please name them:

Medication_____ Taken for _____
Medication_____ Taken for _____
Medication_____ Taken for _____
Medication_____ Taken for_____

- □ Yes □ No □ dk Do you currently have or ever had a substance abuse problem?
- □ Yes □ No □ dk Do you chew or smoke tobacco?
- □ Yes □ No □ dk Operations? Describe _____
- □ Yes □ No □ dk Hospitalized? Describe _____
- □ Yes □ No □ dk Other physical problems or symptoms? Describe_____
- □ Yes □ No □ dk Being treated by another health care professional? For: _____ Date of most recent physical exam _____

□ Yes □ No □ dk Have you ever been told by a physician that you require pre-medication with antibiotics for dental visits?

Do you have any other medical conditions that we should be aware of?

_____

FAMILY MEDICAL HISTORY

Do your parents or siblings have any of the following health problems? If so, please explain.

Bleeding disorder_____ Diabetes_____ Arthritis_____

Metabolic disturbances_____ Severe allergies_____

Unusual dental problems _____ Jaw size imbalance _____

Any other family medical conditions that we should know about? _____

WOMEN ONLY

□ yes □ No □ dk Are you pregnant?
□ Yes □ No □ dk Are you anticipating becoming pregnant?

DENTAL HISTORY

Now or in the past, have you had:

□ Yes □ No □ dk Difficulty chewing or opening jaw?
□ Yes □ No □ dk Tooth grinding or jaw clenching?
□ Yes □ No □ dk Any pain, clicking or locking in jaw or ringing in ears?
□ Yes □ No □ dk Any pain or soreness in the muscles of the face or around the ears?
□ Yes □ No □ dk Have you been treated for TDM or TMJ problems?
□ Yes □ No □ dk Chipped or otherwise injured primary or permanent teeth?
□ Yes □ No □ dk Any teeth irritating cheek, lip, tongue or palate?
□ Yes □ No □ dk Permanent or "extra" (supernumerary) teeth removed?
□ Yes □ No □ dk Supernumerary (extra) or congenitally missing teeth?
□ Yes □ No □ dk Any wisdom tooth problems?
□ Yes □ No □ dk Abnormal swallowing habit (tongue thrusting)?
□ Yes □ No □ dk Thumb, finger or sucking habit? Until what age? _____
□ Yes □ No □ dk Mouth breathing habit, snoring or difficulty in breathing?
□ Yes □ No □ dk Aware of loose, broken or missing restorations (fillings)?
□ Yes □ No □ dk Any serious trouble associated with any previous dental treatment?

□ Yes □ No □ dk Jaw fractures or other trauma to face?
□ Yes □ No □ dk Cysts or mouth infections?
□ Yes □ No □ dk "Gum boils", canker sores or cold sores?
□ Yes □ No □ dk Periodontal (gum) problems?
□ Yes □ No □ dk Had periodontal (gum) treatment?
□ Yes □ No □ dk History of speech problems?
□ Yes □ No □ dk Teeth sensitive to hot or cold?
□ Yes □ No □ dk Teeth that throb or ache?
□ Yes □ No □ dk "Dead" teeth or root canals treated?
□ Yes □ No □ dk Taking any forms of fluoride?
□ Yes □ No □ dk Food impaction between teeth?
□ Yes □ No □ dk Been under another dentist's care?
Specialist _____
Other_____

□ Yes □ No □ dk Would you object to wearing orthodontic appliances (braces) should they be indicated?
□ Yes □ No □ dk Ever had a prior orthodontic examination or treatment?
□ Yes □ No □ dk Are you wearing removable dental appliances? If so, what are they?_____

How often do you brush _____ Floss_____

What is your primary concern? Why are you here? _____

□ Yes □ No □ dk Concerns about spaced, crooked or protruding teeth?
□ Yes □ No □ dk Concerns about under or over developed jaw(s)

I have read and understand the above questions. 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. If there are any changes later to this history record or medical/dental status, I will inform Bracesetters.

Signed:_____ Date Signed:_____
(Patient)

I hereby acknowledge that I have received and reviewed a copy of the Bracesetters' Privacy Notice.

Signed:_____ Date Signed:_____