

# Medical/Dental History - Adult

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Prefers to be addressed by: \_\_\_\_\_ Referred by: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Employed by: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Separated  Widowed

Spouse's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employed by: \_\_\_\_\_ Child's Name: \_\_\_\_\_ Child's Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ DOB: \_\_\_\_\_

Person Responsible for Account:  
 Self  Spouse  Other: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

## DENTAL INSURANCE

Primary Insurance Co: \_\_\_\_\_ Gr.#: \_\_\_\_\_ Ortho Coverage:  Yes  No

Insured's Name: \_\_\_\_\_ SS.#: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Secondary Insurance Co: \_\_\_\_\_ Gr.#: \_\_\_\_\_ Ortho Coverage:  Yes  No

Insured's Name: \_\_\_\_\_ SS.#: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Other Insurance Information: \_\_\_\_\_

## DENTAL HISTORY

Patient's Dentist: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

1. Have there been any injuries to the face, mouth or teeth?  YES  NO

2. Have you had or do you presently have any of the following habits?  
 NO  Thumb or finger sucking  Lip Biting  Snoring  
 Grinding of teeth at night  Mouth breathing

3. Have you been informed of any missing or extra permanent teeth?  YES  NO

4. Are you aware of sores, lumps or irritated areas in the mouth?  YES  NO

5. Has an orthodontist been consulted previously?  YES  NO

Name: \_\_\_\_\_ Date: \_\_\_\_\_

6. Have you ever been treated for:  Bad Bite  TMJ  Periodontal disease  
If so, by whom?: \_\_\_\_\_

7. Do you have any speech problems?  YES  NO

8. Are you frightened or anxious about Orthodontic treatment?  YES  NO

9. Are you concerned about the appearance of your teeth?  YES  NO

10. Is there anything you would like to change about your smile?  
If so, what: \_\_\_\_\_  YES  NO

11. What aspect of dental treatment are you most concerned with?  Quality  Cost  Discomfort  Time

12. Reason for consultation (Chief Concern): \_\_\_\_\_

13. Has there ever been any orthodontic treatment for any other member of your family?  YES  NO  YES  NO Stage of TX: \_\_\_\_\_  
Were they satisfied with the results?

Sons (Dr. \_\_\_\_\_) Daughters (Dr. \_\_\_\_\_) Brothers (Dr. \_\_\_\_\_) Sisters (Dr. \_\_\_\_\_)

