Greater Washington
DENTISTRY
PEDIATRICS | ORTHODONTICS | GENERAL
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Medical Dental History Form for Adult Patients

PATIENT

Date _______________

Patient's Last name __________________________First name _______________________Middle initial__________

Title: ---Mr.----Mrs. ---Ms. ---Miss. ---Dr. Other ___________ I prefer to be called __________________________

Birthdate ___________________ Sex: ---Male ---Female Social Security # ______-_______-_______

Marital Status: ----Single ----Married ----Separated ----Divorced ----Widowed

Home address _______________________________________ City, State, Zip Code_____________________________

Home phone ( ) _____ -______ Cell phone ( )_____-______ Work phone ( ) _____-______

E-mail address(es)____

Occupation ________________ Employer _______________________ Employer's Address_______________________

CLOSEST RELATIVE

Spouse or closest relative's name(s) ____

Relationship to patient ___________________________

Address (if different than patient address)____

Home phone ( )_____-_____ Cell phone ( )____ - _____ Work phone ( )_____-_____

DENTAL INFORMATION

Patient's last dental visit __________________________________ Dentist Name______________

Address, City, State ____ Reason ______________________________

Other dentists/dental specialists now being seen: Name _________________________ City, State ________________

Reason ____

PHYSICIAN

Patient's Physician ______________________ City, State ______________________Phone Number_____________

Last seen ______________ Reason ___________________ Next appointment ___________________

Most recent physical exam ____

Other physicians/health care providers being seen now:

Name ____ City, State _______________________________

Reason____

DENTAL INFORMATION

What concerns you about your teeth? ____

Why did you select our office? ____

Have you had any previous orthodontic consultation or 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 ___________________________
Home phone (   )_____-_____ -Cell 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

MEDICAL INSURANCE

Policy holder's full name ____
Insurance company ____

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

MEDICAL HISTORY

Now or in the past, have you had:

___Yes ___No ___DK/U Birth defects or hereditary problems
___Yes ___No ___DK/U Bone fractures, or major injuries
___Yes ___No ___DK/U Any injuries to face, head, neck
___Yes ___No ___DK/U Arthritis or joint problems
___Yes ___No ___DK/U Endocrine or thyroid problems
___Yes ___No ___DK/U Diabetes or low sugar
___Yes ___No ___DK/U Kidney problems
___Yes ___No ___DK/U Cancer or radiation treatment or chemotherapy
___Yes ___No ___DK/U Stomach ulcer or acid reflux
___Yes ___No ___DK/U Immune system problems
___Yes ___No ___DK/U History of osteoporosis
___Yes ___No ___DK/U Sexually transmitted diseases
___Yes ___No ___DK/U AIDS or HIV positive
___Yes ___No ___DK/U Hepatitis, jaundice, or other liver problem
___Yes ___No ___DK/U Polio, mononucleosis, tuberculosis, pneumonia
___Yes ___No ___DK/U Seizures, fainting, neurologic problem
___Yes ___No ___DK/U Mental health disturbance or depression
___Yes ___No ___DK/U Vision, hearing, or vision problem
___Yes ___No ___DK/U History of eating disorder (anorexia, bulimia)
___Yes ___No ___DK/U Excessive bleeding or bruising anemia
___Yes ___No ___DK/U Chest pain, shortness of breath, tire easily,
___Yes ___No ___DK/U Heart defects, heart murmur, rheumatic heart disease
___Yes ___No ___DK/U Angina, arteriosclerosis, stroke or heart attack
___Yes ___No ___DK/U Skin disorders
___Yes ___No ___DK/U Do you eat a well-balanced diet
___Yes ___No ___DK/U Frequent headaches or migraines
___Yes ___No ___DK/U Frequent colds, ear, throat infections
___Yes ___No ___DK/U Asthma, sinus problems, hayfever
___Yes ___No ___DK/U tonsils/adenoid condition
___Yes ___No ___DK/U Do you frequently breathe through your mouth
Other medical conditions:_______________________________________

DENTAL HISTORY

___Yes ___No ___DK/U Permanent or extra teeth removed
___Yes ___No ___DK/U Extra or congenitally missing teeth
___Yes ___No ___DK/U Chipped or injured primary/permanent teeth
___Yes ___No ___DK/U Any sensitive or sore teeth
___Yes ___No ___DK/U Bleeding gums, bad taste, or mouth odor
___Yes ___No ___DK/U Jaw fracture, cysts, infections
___Yes ___No ___DK/U Any teeth treated with root canals
___Yes ___No ___DK/U "Gum boils" frequent canker/cold sores
___Yes ___No ___DK/U Speech problems or speech therapy
___Yes ___No ___DK/U Difficult breathing through nose
___Yes ___No ___DK/U breathing habit or snoring
___Yes ___No ___DK/U Food impaction between the teeth
___Yes ___No ___DK/U Frequent oral habits
___Yes ___No ___DK/U Abnormal swallowing (tongue thrust)
___Yes ___No ___DK/U Teeth grinding or clenching
___Yes ___No ___DK/U Clicking, locking in jaw joints
___Yes ___No ___DK/U Soreness in jaw muscles or face muscles
___Yes ___No ___DK/U Ringing in ears
___Yes ___No ___DK/U Difficult in chewing or opening jaw
___Yes ___No ___DK/U History of TMJ or TMD problems
___Yes ___No ___DK/U Any broken or missing fillings
___Yes ___No ___DK/U Gum disease or pyorrhea
___Yes ___No ___DK/U Any trouble with previous dental treatment

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

___Yes ___No ___DK/U Local anesthetics (novacaine, lidocaine, xylocaine)
___Yes ___No ___DK/U Latex (gloves, balloons)
___Yes ___No ___DK/U Aspirin
___Yes ___No ___DK/U Ibuprofen (Motrin, Advil)
___Yes ___No ___DK/U Penicillin
___Yes ___No ___DK/U Other antibiotics
___Yes ___No ___DK/U Metals/Acrylics
___Yes ___No ___DK/U Plant pollens
___Yes ___No ___DK/U Animals
___Yes ___No ___DK/U Foods
___Yes ___No ___DK/U Other substances _______________

PATIENT HEALTH INFORMATION

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

Medication ____________________________________ Taken for ____

Medication _____________________________________ Taken for ____

Medication _____________________________________ Taken for ____

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? ____

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

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

FAMILY MEDICAL HISTORY

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

Signature ____ Date_____________________________