Wilson ORTHODONTICS

Adult Medical/Dental History Form

Patient Information

Date: _____

Name: _____

Birth Date: _____ Age: _____ ☐ Male ☐ Female

SSN _____ Home Phone No: _____ Cell No: _____

Address: _____

General Dentist _____ Date of Last Visit: _____

Dentist's Phone No: _____ Address: _____

Who referred you? _____

Responsible Party: _____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Other

☐ Self

Name: _____ Birth-date: ____/____/_____

Address: _____

_____

City State Zip

SS #: _____ DL #: _____

HM #: _____ WK #: _____

CELL #: _____ EMAIL: _____

Employer: _____ Occupation: _____

Employer's Address: _____

_____

City State Zip

Dental Insurance Company: _____

Group #/ ID #: _____

Insurance Address: _____

_____

City State Zip

Insurance Phone #; _____

☐ Spouse ☐ Parent

Name: _____ Birth-date: ____/____/_____

Address: _____

_____

City State Zip

SS #: _____ DL #: _____

HM #: _____ WK #: _____

CELL #: _____ EMAIL: _____

Employer: _____ Occupation: _____

Employer's Address: _____

_____

City State Zip

Dental Insurance Company: _____

Group #/ ID #: _____

Insurance Address: _____

_____

City State Zip

Insurance Phone #; _____

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover. I hereby authorize the orthodontist to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all insurance submissions, whether manual or electronic.

Signature: _____ Date: _____

What is the main concern that you would like orthodontics to address?

_____

_____

Medical History

Physicians Name: _____ Phone #: _____

Address: _____ Last Visit: _____

Now or in the past, have you had:

Yes	No	Birth defects or heredity problems	Yes	No	Vision, hearing, tasting or speech problems
Yes	No	Bone Fractures, any major accidents	Yes	No	Loss of weight recently, poor appetite
Yes	No	Rheumatoid or arthritic conditions	Yes	No	History of eating disorders (anorexia, bulimia)
Yes	No	Endocrine or thyroid problems	Yes	No	Excessive bleeding or bruising tendency, anemia or bleeding disorder
Yes	No	Kidney problems	Yes	No	High or low blood pressure
Yes	No	Diabetes	Yes	No	Tires easily
Yes	No	Cancer, tumor, radiation treatment or chemotherapy	Yes	No	Chest pain, shortness of breath or swelling ankles
Yes	No	Stomach ulcer or hyperacidity	Yes	No	Skin disorder
Yes	No	Polio, mononucleosis or pneumonia	Yes	No	Frequent headaches, colds, or sore throats
Yes	No	AIDS or HIV positive	Yes	No	Eye, ear, nose or throat condition
Yes	No	Hepatitis, jaundice or liver problems	Yes	No	Hay-fever, asthma, sinus trouble or hives
Yes	No	Fainting, seizures, epilepsy or neurological problems	Yes	No	Tonsil or adenoid conditions
Yes	No	Mental health disturbance or behavior problems	Yes	No	Hospitalizations/Operations
Yes	No	Damaged heart valves, artificial valves or heart murmur	Yes	No	Smoke or chew tobacco

Allergies or reactions to any of the following:

Yes	No	Local anesthetics (lidocaine)	Yes	No	Latex (gloves, balloons)
Yes	No	Aspirin	Yes	No	Vinyl
Yes	No	Ibuprofen (Motrin, Advil)	Yes	No	Acrylic
Yes	No	Penicillin or other antibiotics	Yes	No	Animals
Yes	No	Sulfa drugs	Yes	No	Foods (specify):
Yes	No	Codeine or other narcotics	Yes	No	Iodine
Yes	No	Metals (jewelry, clothing snaps)	Yes	No	Other substances (specify):

Please list all medications (prescribed, non-prescribed, herbal and nutrient supplements) and dosage:

_____

Women only:

Yes	No	Are you pregnant?
Yes	No	Are you anticipating becoming pregnant?

Dental History

Now or in the past, have you had:

Yes	No	Teething very early or late	Yes	No	Tooth grinding, jaw clenching, clicking or locking
Yes	No	Primary (baby) teeth removed that were not loose	Yes	No	Any pain in jaw or ringing in the ears
Yes	No	Permanent or “extra” (supernumerary) teeth removed	Yes	No	Any pain soreness in the muscles in the face or around the ear
Yes	No	Supernumerary (extra) teeth or congenitally missing teeth	Yes	No	Difficulty encountered in chewing or jaw opening
Yes	No	Chipped or otherwise injured baby or permanent teeth	Yes	No	Loose, broken or missing restoration (fillings, crowns)
Yes	No	Teeth sensitivity to hot or cold; tooth throb or ache	Yes	No	Any teeth irritating the cheek, lip, tongue or palate
Yes	No	Jaw fractures, cysts or mouth infections	Yes	No	Concern about spaced, crooked or protruding teeth
Yes	No	“Dead teeth” or root canal treatment	Yes	No	“Gum boils”, frequent canker sores or cold sores
Yes	No	Bleeding gums, bad taste or mouth odor	Yes	No	Any forms of fluoride
Yes	No	Periodontal “gum problems”	Yes	No	Any family member with similar tooth or jaw relationships
Yes	No	Food impaction between teeth	Yes	No	Periodontal (gum) treatment
Yes	No	Thumb, finger or sucking habits; Until what age: ___	Yes	No	Any serious trouble associated with previous dental treatment
Yes	No	Abnormal swallowing habit (tongue thrusting)	Yes	No	Prior orthodontic exam or treatment
Yes	No	History of speech problems			
Yes	No	Mouth breathing habit, snoring or difficulty in breathing			

How often do you brush: _____

How often do you floss: _____

If you currently or in the past have taken a biphosphonate drug such as **Fosmax, Actonel or Boniva** for osteoporosis or osteopenia, be aware that there is a potential for developing osteonecrosis. Osteonecrosis results in failure to heal and can lead to other lethal complications, including, but not limited to, bone and tissue destruction and possible disfigurement. **It is extremely important that the doctor is informed if you are currently or have in the past taken any of these drugs. It is very important that the doctors informed if you fail to heal properly**.

I certify that I have read and understand all of the information included on this document. I acknowledge that my questions, if any, about the inquires set forth in this document have been answered to my satisfaction. I will not hold my orthodontist or any member of the staff responsible for any errors or omissions that I may have made in completing this document. I authorize the orthodontist and the staff to perform the necessary orthodontic or dental services I may need.

_____ _____

Signature Date

Medical History Update

Has there been any change in your health status? Yes No
If yes, explain _____
_____

_____ _____
Signature Date

_____ _____
Doctor Signature Date

Has there been any change in your health status? Yes No
If yes, explain _____
_____

_____ _____
Signature Date

_____ _____
Doctor Signature Date