CONFIDENTIAL

Medical Dental History Form For Adult Patients

PATIENT

Date _____

Patient's last name _____ First Name _____ MI _____

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

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

Home address _____ City, state, zip code _____

Cell phone _____ Work phone _____

Email 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's address)* _____

Cell phone _____ Work phone _____

DENTIST

Patient's Dentist _____ Address, City, State _____

Last seen _____ Reason _____ Next appointment _____

Other dentist/dental specialists being seen _____ City, State _____

Reason _____

GENERAL INFOMATION

What concerns you about your teeth? _____

Who suggested that you might need orthodontic treatment? _____

Why did you select our office? _____

Describe any previous orthodontic treatment _____

Please name any family members that have bee treated in this office: _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____

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

Cell phone _____ Email address(es) _____

Social Security # _____ Employer _____

DENTAL INSURANCE

Primary policy holder's full name _____ Birth date _____

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 _____ Birth date _____

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

Now or in the past, have you had:

Yes	No	DK/U	
☐	☐	☐	Have you ever taken intravenous medication for bone disorders of cancer such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate)?
☐	☐	☐	Have you ever taken oral medication for bone disorders such as bisphosphonates Fosamax (alendronate), Skelid (tiludronate) Actonel (ridendronate), Boniva (ibandronate), or Didronal (etidronate)?
☐	☐	☐	Heredity of developmental conditions?
☐	☐	☐	Bone fractures, or major injuries?
☐	☐	☐	Any injuries to face, head, or neck?
☐	☐	☐	Arthritis or joint problems?
☐	☐	☐	Endocrine or thyroid problems?
☐	☐	☐	Diabetes or low sugar?
☐	☐	☐	Kidney problems?
☐	☐	☐	Stomach ulcer, hyperacidity, acid reflux?
☐	☐	☐	Immune systems problems?
☐	☐	☐	Cancer, tumor, radiation treatment, or chemotherapy
☐	☐	☐	Gonorrhea, syphilis, herpes, sexually transmitted diseases

Yes	No	DK/U	
☐	☐	☐	Excessive bleeding or bruising, anemia?
☐	☐	☐	Angina, arteriosclerosis, stroke, 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?
☐	☐	☐	AIDS or HIV positive
☐	☐	☐	Hepatitis, jaundice, or other liver problems?
☐	☐	☐	Polio, mononucleosis, tuberculosis, pneumonia?
☐	☐	☐	Seizures, fainting spells, neurological problems?
☐	☐	☐	Mental health disturbances or depression?
☐	☐	☐	Vision, hearing, or speech problems?
☐	☐	☐	History of eating disorder?
☐	☐	☐	High or low blood pressure?
☐	☐	☐	Chest pain, shortness of breath, tire easily, swollen ankles?
☐	☐	☐	Heart defects, heart murmur, rheumatic heart disease?

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

Yes	No	DK/U	
☐	☐	☐	Local anesthetics (novocaine, lidocaine)
☐	☐	☐	Latex (gloves, balloons)
☐	☐	☐	Aspirin
☐	☐	☐	Ibuprofen (Motrin, Advil)
☐	☐	☐	Penicillin
☐	☐	☐	Other antibiotics

Yes	No	DK/U	
☐	☐	☐	Metals (jewelry, clothing snaps)
☐	☐	☐	Acrylics
☐	☐	☐	Plant pollens
☐	☐	☐	Animals
☐	☐	☐	Foods
☐	☐	☐	Other substances _____

DENTAL HISTORY

Now or in the past, have you had:

Yes	No	DK/U		Yes	No	DK/U	
☐	☐	☐	Chipped or injured primary or permanent teeth?	☐	☐	☐	Frequent oral habits (sucking fingers, etc)?
☐	☐	☐	Bleeding gums, bad taste, or mouth odor?	☐	☐	☐	Teeth causing irritation to lip, cheek, or gums?
☐	☐	☐	Primary (baby) teeth removed that were not loose?	☐	☐	☐	Abnormal swallowing (tongue thrust)?
☐	☐	☐	Permanent or extra teeth removed?	☐	☐	☐	Tooth grinding or clenching?
☐	☐	☐	Supernumerary(extra) or congenitally missing teeth?	☐	☐	☐	Clicking, locking in jaw joints?
☐	☐	☐	Any lost or broken fillings?	☐	☐	☐	Soreness in jaw muscles or face muscles?
☐	☐	☐	Jaw fractures, cysts, infections?	☐	☐	☐	Ringing in ears, difficulty chewing or opening jaw?
☐	☐	☐	Any teeth treated with root canas or pulpotomies?	☐	☐	☐	Does your child frequently breath through their mouth?
☐	☐	☐	“Gum boils”, frequent canker sores or cold sores?				
☐	☐	☐	History of speech problems or speech therapy?	☐	☐	☐	Have you evere been treated for TMJ or TMD problems?
☐	☐	☐	Difficulty breathing through nose?				
☐	☐	☐	Mouth breathing habit or snoring at night?	☐	☐	☐	Any serious trouble associated with previous dental treatment?
☐	☐	☐	History of speech problems or speech therapy?				
☐	☐	☐	Frequent headaches or migraines?	☐	☐	☐	Have you ever been diagnosed with gum disease or pyorrhea?
☐	☐	☐	Any sensitive or sore teeth?				
☐	☐	☐	Food impaction between the teeth?	☐	☐	☐	Have you ever had an orthodontic consultation or treatment before now?
☐	☐	☐	Mouth breathing habit or snoring at night?				

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 noticed any unusual changes in your child’s face or jaws? _____

Any other physical problems? _____

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

Are you pregnant? ☐ Yes ☐ No Are you trying to become pregnant? ☐ Yes ☐ No

RELEASE AND WAIVER

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

Signature _____ Date _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of their 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 _____

Patient Motivation for Treatment

Patient's Name:_____ Date: _____

Patients often request changes in their bite and relief from pain or discomfort. Please help us understand your problem by checking the following information; please be specific.

TEETH: If your teeth could be changed, how would you like them to change?

- ☐ straighten the **upper** front teeth
- ☐ straighten the **lower** front teeth
- ☐ straighten the **upper** back teeth
- ☐ straighten the **lower** back teeth
- ☐ make the upper front teeth **longer**
- ☐ make the upper front teeth **shorter**
- ☐ move upper teeth **forward**
- ☐ move upper teeth **backward**
- ☐ move lower teeth **forward**
- ☐ move lower teeth **backward**
- ☐ make the line of the upper front teeth more level
- ☐ other: _____

THE FACE: If your facial appearance could be changed, what would you change?

- ☐ get rid of the sag under lower jaw
- ☐ move chin **more center**
- ☐ move chin **forward**
- ☐ move chin **left**
- ☐ move chin **backward**
- ☐ move chin **right**
- ☐ move lower lip **forwards**
- ☐ move lower lip **backward**
- ☐ move upper lip **forward**
- ☐ move upper lip **backward**
- ☐ move the area around the nose **forward**
- ☐ move the area around the nose **backward**
- ☐ make the profile of my nose **longer**
- ☐ make the profile of my nose **shorter**
- ☐ move the area under my eyes **forward**
- ☐ move the area under my eyes **backward**
- ☐ make the cheekbones **larger**
- ☐ make the cheekbones **smaller**
- ☐ show **more** of my teeth when I smile
- ☐ show **more** of my gums when I smile
- ☐ show **less** of my teeth when I smile
- ☐ show **less** of my gums when I smile
- ☐ make my lips **closer together** when my teeth are touching
- ☐ make my lips **farther apart** when my teeth are touching
- ☐ reduce the strain in my **lips** when my lips are touching
- ☐ reduce the strain in my **chin** when my lips are touching
- ☐ make my face more **narrow**
- ☐ make my face more **wide**
- ☐ reduce the width of my lower jaw behind my mouth
- ☐ make my lips not touch and roll out when my teeth are touching
- ☐ other: _____

SYMPTOMS: If you want to reduce pain or discomfort, where is it located?

- ☐ in front of my **right** ear
- ☐ in front of my **left** ear
- ☐ below my **right** ear
- ☐ below my **left** ear
- ☐ above my **right** ear
- ☐ above my **left** ear
- ☐ **right side** of my temples
- ☐ **left side** of my temples
- ☐ teeth
- ☐ sinuses
- ☐ other: _____

- ☐ in my **right** ear
- ☐ in my **left** ear
- ☐ **left side** of my neck
- ☐ **right side** of my neck
- ☐ **right side** of my shoulders
- ☐ l**eft side** of my shoulders
- ☐ **right** eye
- ☐ l**eft** eye

Patient Consent Form

L. Douglas Knight, DMD, ABO

I understand, that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third-party payers.

- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____ Date: _____
(Please Print)

Parent/Guardian Signature: _____