FELLER ORTHODONTICS

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ADULT MEDICAL DENTAL HISTORY FORM

Date: _____

Patient's Last Name: _____ First Name: _____ Middle Name/Initial: _____

Birth Date: _____ Age: _____ Sex: Male Female Prefers To Be Called: _____ S.S.N. _____

Patient's Address: _____

City: _____ State/Province: _____ Postal Code: _____ Home Phone No.: (_____) _____-_____

E-mail address: _____ Cell phone: (_____) _____-_____

Preferred method of appointment reminder: Text Email Preferred Method to receive general correspondence: Mail Email

Marital Status Single Married Separated Divorced Widowed Sports And/Or Hobbies: _____

Other family members treated here: _____

Spouse or closest relative's name(s) _____ Relationship to patient _____

Address *(if different than patient address)* _____

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

Name Of Dentist: _____ Date Last Seen: _____ Reason: _____

Dentist's Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____ Phone No.: (_____) _____-_____

Name Of Physician (s): _____ Date Last Seen: _____ Reason: _____

Physician's Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____ Phone No.: (_____) _____-_____

Who Is Financially Responsible For This Account? Last Name: _____ First Name: _____ MI: _____

Address (if different from patient's): _____

Years at address: _____

If less than five years, previous address: _____

Phone No. (if different than patient's): (_____) _____-_____ S.S.N/S.I.N .: _____

Employer: _____ How many years? _____

Insurance Coverage For Dental Treatment? Yes No Insurance Coverage For Orthodontic Treatment? Yes No

Primary Policy Holder's Name: _____ S.S.N./S.I.N.: _____ Birth Date: _____

Employed By: _____ Dental Insurance Company: _____ Group No. _____

Secondary Policy Holder's Name: _____ S.S.N./S.I.N.: _____ Birth Date: _____

Employed By: _____ Dental Insurance Company: _____ Group No. _____

Medical Insurance Company: _____ Group No. _____

PRIMARY CONCERN

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

_____

Who suggested that you might need orthodontic treatment? _____

Why did you select our office? _____

For the following questions mark yes, no, or don't know/understand (dk/u). 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/u Birth defects or hereditary problems?
yes no dk/u Bone fractures, any major accidents?
yes no dk/u Rheumatoid or arthritic conditions?
yes no dk/u Endocrine or thyroid problems?
yes no dk/u Kidney problems?
yes no dk/u Diabetes?
yes no dk/u Cancer, tumor, radiation or chemotherapy?
yes no dk/u Stomach ulcer or hyperacidity?
yes no dk/u Polio, mononucleosis, tuberculosis or pneumonia?
yes no dk/u Problems of the immune system?
yes no dk/u AIDS or HIV positive?
yes no dk/u Hepatitis, jaundice or liver problem?
yes no dk/u Fainting spells, seizures, epilepsy or neurological problem?
yes no dk/u Mental health disturbance or behavioral problem?
yes no dk/u Vision, hearing, tasting or speech difficulties?
yes no dk/u Loss of weight recently, poor appetite?
yes no dk/u History of eating disorder (anorexia, bulimia)?
yes no dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?
yes no dk/u High or low blood pressure?
yes no dk/ u Tires easily?
yes no dk/u Chest pain, shortness of breath or swelling ankles?
yes no dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
yes no dk/u Skin disorder?
yes no dk/u Do you eat a well-balanced diet?
yes no dk/u Frequent headaches, colds or sore throats?
yes no dk/u Eye, ear, nose or throat condition?
yes no dk/u Hayfever, asthma, sinus trouble or hives?
yes no dk/u Tonsil or adenoid conditions?
yes no dk/u Do you currently have/had a substance abuse problem?
yes no dk/u Do you chew or smoke tobacco?
yes no dk/u Operations? Describe: _____
yes no dk/u Hospitalized? For: _____
yes no dk/u Other physical problems or symptoms?
Describe: _____
yes no dk/ u Being treated by another health care professional? For:
_____

Bleeding disorders:

Diabetes:

Arthritis:

Metabolic disturbances:

Severe allergies:

Unusual dental problem:

Jaw size imbalance:

Any other family medical conditions that we should know about?

WOMEN ONLY

yes no dk/u Are you pregnant?

PATIENT PROFILE

yes no dk/u Do you brush your teeth conscientiously?
yes no dk/u Are you sensitive or self-conscious about teeth?

Medication	Taken for
Medication	Taken for
Medication	Taken for

yes no dk/u Are you taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.
Date of most recent physical exam? _____
Are there any other medical conditions that we should be aware of?

_____

Allergies or reactions to any of the following:

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

FAMILY MEDICAL HISTORY

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

DENTAL HISTORY

Now or in the past, have you had:

yes no dk/u Started teething very early or late?

yes no dk/u Primary (baby) teeth removed that were not loose?

yes no dk/u Permanent or "extra" (supernumerary) teeth removed?

yes no dk/u Supernumerary (extra) or congenitally missing teeth?

yes no dk/u Chipped or otherwise injured primary (baby) or permanent teeth?

yes no dk/u Teeth sensitive to hot or cold; teeth throb or ache?

yes no dk/u Jaw fractures, cysts or mouth infections?

yes no dk/u "Dead teeth" or root canals treated?

yes no dk/u Bleeding gums, bad taste or mouth odor?

yes no dk/u Periodontal "gum problems"?

yes no dk/u Food impaction between teeth?

yes no dk/u Thumb, finger, or sucking habit? Until what age _____

yes no dk/u Abnormal swallowing habit (tongue thrusting)?

yes no dk/u History of speech problems?

yes no dk/u Mouth breathing, snoring or difficulty in breathing?

yes no dk/u Tooth grinding, jaw clenching clicking or locking?

yes no dk/ u Any pain in jaw or ringing in the ears?

yes no dk/u Any pain or soreness in the muscles of the face or around the ears?

yes no dk/u Difficulty encountered in chewing or jaw opening?

yes no dk/u Aware of loose, broken/missing restorations (fillings)?

yes no dk/u Any teeth irritating cheek, lip, tongue or palate?

yes no dk/u Concerned about spaced, crooked or protruding teeth?

yes no dk/u Aware or concerned about under or over developed jaw?

yes no dk/u "Gum Boils", frequent canker sores or cold sores?

yes no dk/u Taking any forms of fluoride?

yes no dk/u Any relative with similar tooth or jaw relationships?

yes no dk/u Had periodontal (gum) treatment?

yes no dk/u Would patient object to wearing orthodontic appliances (braces) should they be indicated?

yes no dk/u Any serious trouble associated with any previous dental treatment?

yes no dk/u Ever had a prior orthodontic examination or treatment?

yes no dk/u Been under another dentist's care?
Specialist _____
Other _____

How often does you brush? _____ Floss? _____

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 so inform this practice.

Signed: _____ Date Signed: _____
(Patient)

Signed: _____ Date Signed: _____
(Dental Staff Member)