American Association of Orthodontists®

My Life. My Smile. My Orthodontist.®

Medical Dental History Form for Adult Patients

CONFIDENTIAL

Patient

Date 03/03/2022

Patient's last name ______ First name ______ Middle initial ______

Title Mr. Mrs. Ms. Miss. Dr. Other ______ I prefer to be called ______

Birth date ______ Sex ☐ Male ☐ Female Social Security # ______

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

Home address ______ City, State, Zip code ______

Home phone ( ) ___-___ Cell phone ( ) ___-___ Work phone ( ) ___-___

Email Address(es) ______

Occupation ______ Employer ______

Closest Relative

Spouse or closest relatives name(s) ______

Title Mr. Mrs. Ms. Miss. Dr. Other ______ Relationship to patient ______

Address *(If different than patient address)* ______

Home Phone *(If different)* ( ) ___-___ Cell phone ( ) ___-___ Work phone ( ) ___-___

Dentist

Patient's Dentist ______ **Phone Number*** ______

Last seen ______ Reason ______ Next appointment ______

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

Reason ______

Physician

Patient's Physician ______ **Phone Number** ______

General Information

What concerns you about your teeth? ___

Who suggested that you might need orthodontic treatment? ___

Why did you select our office? ___

Have you had any previous orthodontic 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 than page 1)* ___ City, State, Zip ___

Home phone ( ) ___-___ 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

Medical Insurance

Policy holder's full name ___

Insurance Company ___

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, please 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?
☐	☐	☐	Bone fractures or major injuries?
☐	☐	☐	Any injuries to face, head, neck?
☐	☐	☐	Arthritis or joint problems?
☐	☐	☐	Endocrine or thyroid problems?
☐	☐	☐	Diabetes or low sugar?
☐	☐	☐	Kidney problems?
☐	☐	☐	Cancer, tumor, radiation treatment or chemotherapy?
☐	☐	☐	Stomach ulcer, hyperacidity, acid reflux?
☐	☐	☐	Immune system problems?
☐	☐	☐	History of osteoporosis?
☐	☐	☐	Gonorrhea, syphilis, herpes, sexually transmitted diseases?
☐	☐	☐	AIDS or HIV positive?
☐	☐	☐	Hepatitis, jaundice, or other liver problems?
☐	☐	☐	Polio, mononucleosis, tuberculosis, pneumonia?
☐	☐	☐	Seizures, fainting spells, neurologic problems?
☐	☐	☐	Mental health disturbance or depression?
☐	☐	☐	Vision, hearing, or speech problems?
☐	☐	☐	History of eating disorder (anorexia, bulimia)?
☐	☐	☐	High or low blood pressure?
☐	☐	☐	Excessive bleeding or bruising, anemia?
☐	☐	☐	Chest pain, shortness of breath, tire easily, swollen ankles?
☐	☐	☐	Heart defects, heart murmur, rheumatic heart disease?
☐	☐	☐	Angina, arteriosclerosis, stroke or 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?

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

Yes	No	DK/U	
☐	☐	☐	Local anesthetics (novocaine, lidocaine, xylocaine)
☐	☐	☐	Latex (gloves, balloons)
☐	☐	☐	Aspirin
☐	☐	☐	Metals (jewelry, clothing snaps)
☐	☐	☐	Penicillin
☐	☐	☐	Other antibiotics
☐	☐	☐	Ibuprofen (Motrin, Advil)
☐	☐	☐	Acrylics
☐	☐	☐	Plant pollens
☐	☐	☐	Animals
☐	☐	☐	Foods
☐	☐	☐	Other substances ____________________

Dental History

Now or in the past, have you had:

Yes	No	DK/U	
☐	☐	☐	Permanent or extra (supernumerary) teeth removed?
☐	☐	☐	Supernumerary (extra) or congenitally missing teeth?
☐	☐	☐	Chipped or injured primary or permanent teeth?
☐	☐	☐	Any sensitive or sore teeth?
☐	☐	☐	Bleeding gums, bad taste or mouth odor?
☐	☐	☐	Jaw fractures, cysts, infections?
☐	☐	☐	Any teeth treated with root canals or pulpotomies?
☐	☐	☐	"Gum boils," frequent canker sores or cold sores?
☐	☐	☐	History of speech problems or speech therapy?
☐	☐	☐	Difficulty breathing through nose?
☐	☐	☐	Food impaction between the teeth?
☐	☐	☐	Mouth breathing habit or snoring at night?
☐	☐	☐	Frequent oral habits (sucking finger, chewing pen, etc)?
☐	☐	☐	Teeth causing irritation to lip, cheek or gums?
☐	☐	☐	Abnormal swallowing (tongue thrust)?
☐	☐	☐	Tooth grinding or clenching?
☐	☐	☐	Clicking, locking in jaw joints?
☐	☐	☐	Soreness in jaw muscles or face muscles?
☐	☐	☐	Ringing in ears, difficulty in chewing or opening jaw?
☐	☐	☐	Have you ever been treated for "TMJ" or "TMD" problems?
☐	☐	☐	Any broken or missing fillings?
☐	☐	☐	Any serious trouble associated with previous dental treatment?
☐	☐	☐	Have you ever been diagnosed with gum disease or pyorrhea?
☐	☐	☐	Have you ever had an orthodontic consultation or treatment before now?

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? ____________________

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? ____________________

I have read the above questions and understand them. 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. I will notify my orthodontist of any changes in my medical or dental health.

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PHOTO RELEASE

I, ________________________, do hereby relinquish any and all rights to photographs, portraits, transparancies, negatives, prints, polaroids or other photographic reproductions captured with still, motion picture, video, digital or other cameras for use by Dr.Maria Mendez, and or All About Smiles Orthodontics.

PATIENT INFORMATION

Patient's Name: ________________________

Patient's Address: ________________________

City, State: ________________________

Zip Code: ________________________

Phone #: ________________________

Work #: ________________________

SCHEDULING INFORMATION

Our scheduling system has several goals: We want to see you on time for your appointment and we want to have plenty of time during each appointment to do the necessary treatments, to give you information about your treatment, and to answer any questions. We also want to work with you around your school and work hours as much as possible. Therefore we need both structure and flexibility in our scheduling system.

Here are some aspects of the scheduling system that we feel are important:

Between 2:00 pm and 4:30 pm we schedule many short appointments so that as many patients as possible do not have to miss school or work. We provide school/work excuses for orthodontic appointments.

> **Arriving Late:** Because the schedule is carefully crafted, your late arrival can cause a problem in the flow of the appointments. In fairness to all other scheduled patients, we will most likely offer to reschedule your appointment. If you choose to wait and be seen, you will have to wait until all other patients that arrived on time are seen.
>
> **Long Appointments:** These are more detailed and technique-sensitive appointments. For this reason these appointments will be scheduled during our morning hours.
>
> **Repairs:** These appointments are scheduled during morning hours.
>
> **Broken Appointments:** We can usually re-schedule a missed appointment in the morning. You might have to wait 6-8 weeks for an after school/work appointment, since they are scheduled that far in advance.
>
> **Short Appointments:** You may be amazed, concerned or confused about how short some of the appointments are. We often must see the patient for a short visit to monitor tooth movement without making complex adjustments.

We thank you in advance for your cooperation.

I have read and understand the All About Smiles scheduling policies.

_____________________ _____________________

Signature Date