



## **Medical Dental History Form for Adult Patients**

Date//								
Name			Birth Date	_//_	Age			
			City		Zip Code_			
Cell Phone	s may be verified by text messages	_Email						
	3 may be verified by text messages		Business	Phone				
Emergency Contact		PhoneRelationship						
Names and ages of childre	en under 18							
Do you have insurance of	overage for orthodontic treatment	? Yes No						
Employee Name	ID#	SS	N#		Birth Date_	/_	/_	
Insurance Company	Employer_		Group #	<b>#</b>				
Employee Name	ID#							
Insurance Company	Employer_		Group #	<i></i>				
Medical/Dental History								
Yes No Do you have Yes No Do you have Yes No Do you have Yes No Have you tak	tion (antibiotics) required for dental properties and any allergies or drug sensitivities including any medical history that you feel the any medical history that you feel the en any medication for bone disorders for bone f	uding anesthetics, la orthodontist should b orthodontist should b s such as bisphospho	tex, metals etc.? (I be aware of? (If Yes be aware of. (If Yes be aware of. (If Yes be aware	f Yes – lis s – explai s – explai Actonel, Z eech Prob ury to Mou ury to Fac ental Healt pression riodontal/0	n on reverse si n on reverse si 'ometa, Aredia, olems uth/Teeth	de) de)		
Yes No Women: Are Yes No Have you be Yes No Have you even Yes No Have you even What concerns you about Who suggested that you now Why did you select our off Have you ever had any properties of Have you had previous or Have any family members Who is your dentist?	e you pregnant, possibly pregnant or the informed of any missing or extra per been told you have TMJ/TMD prober had or been treated for periodontal your teeth?	trying to become pre permanent teeth? plems or been treated I (gum) disease or re  nt?	gnant? d for TMJ/TMD? ecession?					
omissions that I have mad I authorize release of any	stions and understand them. I will no e in the completion of this form. I will information regarding my orthodontic	notify my orthodontis treatment to my den	et of any changes in tal and/or medical	n my med insurance	lical or dental he company.	ealth.	TOTS	· Or
Signature			Date					

Medical/Dental History – Explanations:		
Are you in good health? (If No – explain)		_
Are you physically, mentally, or emotionally impaired? (If Yes – explain)		
Are you or have you been under the care of a physician for a major illness? (If Yes – explain)		
Are you taking any medications or drugs? (If Yes – list and explain)		
Is premedication (antibiotics) required for dental procedures? (If Yes – explain)		
Do you have any allergies or drug sensitivities including anesthetics, latex, metals etc.? (If Yes	– list)	=
Do you have any medical history that you feel the orthodontist should be aware of? (if Yes – ex	plain)	_
Please use the following if additional space is needed:		
Medical Dental History Updates or Changes Changes		
Patient Signature	Date	
Dental Staff Signature	Date	
Changes		
Patient Signature Dental Staff Signature	Date Date	
·	Date	
Changes Patient Signature	Date	
Dental Staff Signature	Date	