

Confidential

**R. Steven Powell, DMD, PC
Orthodontist
Medical - Dental History Form - Adult**

Date _____

Whom may we thank for referring you to our office ? _____

Patient's Last Name _____ First _____ Middle _____ Preferred name _____

Birthdate _____ Age _____ Sex : Male Female Home Phone # _____

Patient's Home Address -Street _____

City _____ State _____ ZipCode _____

Patient's Height _____ Weight _____ Musical instrument played _____

Favorite Sports, Hobbies, and Avocations _____

Employed by _____ Phone # _____

Business Address _____ Soc Sec No _____

Patient is: Single Married Separated Divorced Widowed

Name of spouse/closest relative _____ Phone # _____

His/her address (if different from yours) _____ City _____ State _____ Zip _____

Name of Person Responsible for Account _____ Relationship to patient _____

Responsible parties occupation _____ DOB _____ Soc Sec No _____

Employed by _____ Phone # _____

Business Address _____ City _____ State _____ Zip _____

Name of Patient's Dentist _____ Phone # _____

Name of Patient's Physician _____ Phone # _____

In case we cannot reach you: Person to contact _____ Phone # _____

Do you have dental insurance that covers orthodontic treatment Yes No *If yes, please bring your insurance card with you.*

Primary Insurance Company _____ Policy No. _____

Subscriber FULL Name _____ DOB _____

Subscriber SSN _____ Relationship to Patient is _____ Child _____ Spouse _____ Self _____ Other _____

Employer Name _____

Secondary Insurance Company _____ Policy No. _____

Subscriber FULL Name _____ DOB _____

Subscriber SSN _____ Relationship to Patient is _____ Child _____ Spouse _____ Self _____ Other _____

Employer Name _____

I hereby authorize release of any information necessary or relating to processing any insurance claim.

Signature of Patient, or Parent if Minor _____ Date _____

I hereby authorize payment directly to the provider of the insurance benefits otherwise payable to me.

Signature of Patient, or Parent if Minor _____ Date _____

For the following questions circle **yes, no, or don't know/understand (dk/u)**. The answers are for our office records only and will be considered confidential. A thorough and complete history is vital to proper orthodontic evaluation.

Medical History

- yes no dk/u Birth defects or hereditary problems?
- yes no dk/u Bone fractures or 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 or been treated for a tumor?
- yes no dk/u Stomach or hyperacidity?
- yes no dk/u Polio, mono, 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 problems?
- yes no dk/u Fainting spell, seizures, epilepsy or neurologic problems?
- yes no dk/u Mental health or behavioral problems?
- yes no dk/u Vision, hearing, tasting or speech difficulties?
- yes no dk/u Recent loss of weight?
- yes no dk/u Excessive bleeding, black and blue 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 or rheumatic heart)
- yes no dk/u Skin disorder?
- yes no dk/u Do you have a normal or good 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 Are you taking any medication or non-prescription medicine? Please name them.
- yes no dk/u Are you allergic or sensitive to any medications? Please list:
- yes no dk/u Operations? (surgical procedures)

- yes no dk/u Hospitalized for
- yes no dk/u Other physical problems or symptoms?
- yes no dk/u Being treated by another healthcare professional?
- For
- Date of most recent physical

Female Patient:

- yes no dk/u Are you or might you be pregnant?
- yes no dk/u Are you taking birth control pills?
- yes no dk/u Are you anticipating becoming pregnant?

Dental History

- yes no dk/u Permanent or "extra" teeth removed?
- yes no dk/u Congenitally missing teeth?
- yes no dk/u Chipped or otherwise injured baby or permanent teeth?
- yes no dk/u Teeth sensitive to hot, 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 or periodontal disease?
- yes no dk/u Frequent fever blisters, canker sores or cold sores?
- yes no dk/u Thumb or finger sucking habit? Until
- yes no dk/u Abnormal swallowing habit (tongue thrust)?
- yes no dk/u History of speech problems?
- yes no dk/u Mouth breathing or difficulty in breathing?
- yes no dk/u Clicking or locking jaw?
- yes no dk/u Pain in jaw or ringing in ears?
- yes no dk/u Any pain or soreness in the muscles of the face or around the ears?
- yes no dk/u Difficulty in chewing or jaw opening?
- yes no dk/u Have you ever been treated for "TMJ" problems (your jaw joint and facial muscle pain)?
- yes no dk/u Aware of loose or broken fillings?
- yes no dk/u Concerned about spaced, crooked or protruding teeth?
- yes no dk/u Have you ever had any orthodontic treatment or worn a "retainer"?
- yes no dk/u Have you ever had periodontal (gum) treatment?
- yes no dk/u Aware or concerned about under or over developing jaw relationship?
- yes no dk/u Any relative with similar tooth or jaw relationship?
- yes no dk/u Have you had any serious trouble associated with any previous dental treatment?

yes no dk/u Have you ever had a prior orthodontic examination or treatment?

yes no dk/u Have you recently been under another dentist's care?

Specialist

Other

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

Date of most recent dental examination

What is the your primary concern? - Why are you here?

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene; are there any restrictions, handicaps or problems that might be encountered during treatment?

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form.

If there are changes later to this history record or medical/dental status I will so inform this practice.

Signature of patient

Date

**Medical History Update or Changes Date: Comments:
Signature:**