

Registration and Medical History –**Adult**

Consult Date \_\_\_\_\_

**Patient's** Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Preferred name/nickname \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex M / F \_\_\_\_\_

Marital status:            Single    Married    Widowed    Separated    Divorced

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Complete Home Address \_\_\_\_\_

\_\_\_\_\_

Name of Patient's **Dentist** \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Date last seen \_\_\_\_\_ Reason \_\_\_\_\_

Who suggested that you might need orthodontic treatment? \_\_\_\_\_

Why did you select our office? \_\_\_\_\_

Who is financially responsible for this account? \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Address (if different than patient's) \_\_\_\_\_

Name of Patient's **Physician** \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Date last seen \_\_\_\_\_ Reason \_\_\_\_\_

**MEDICAL HISTORY:** Answer every question by circling Y (yes) N (no) U (unsure).

Were you ever diagnosed with the following?: Taking medications for?(list)

Y N U Birth defects or hereditary problem?

Y N U Bone fractures or major accident?

Y N U Rheumatoid or arthritic conditions?

Y N U Endocrine or thyroid problems?

Y N U Kidney problems?

Y N U Diabetes?

Y N U Cancer, tumor, radiation or chemo treatment?

Y N U Stomach ulcer or hyperacidity?

Y N U Polio, mononucleosis, tuberculosis or pneumonia?

Y N U Immune system problems?

Y N U AIDS or HIV?

Y N U Hepatitis, Jaundice, or liver problems?

Y N U Fainting spells, seizures, epilepsy or neurological problems?

Y N U Mental health disturbance or depression?

Y N U Vision, hearing, tasting or speech difficulties?

Y N U Rapid unintentional weight loss, loss of appetite?

Y N U Eating disorder, anorexia, bulimia?

Y N U High or low blood pressure?

Y N U Unusually tired or chronic fatigue?

Y N U Chest pain, shortness of breath or ankle swelling?

Y N U Cardiovascular problem (heart trouble, angina, stroke, heart defect?)

Y N U Heart murmur that requires antibiotic premedication for dental visits?

Y N U Skin disorder?

Y N U Osteoporosis?

Y N U Frequent headaches, colds or sore throat?

Y N U Eye, ear, nose or throat condition?

Y N U Hayfever, asthma, sinus trouble or hives?

Y N U Tonsil or adenoid condition?

**Allergies or reactions to any of the following?:**

Y N U Latex (gloves, balloons)

Y N U Ibuprofen (Motrin, Advil)

Y N U Metals (jewelry, clothing snaps)

Y N U Aspirin

Y N U Acrylic or Vinyl

Y N U Penicillin or other antibiotics

Y N U Foods

Y N U Sulfa drugs

Y N U Animals

Y N U Codeine or other narcotics

Y N U Other

Y N U Local anesthetics (Novocaine)

**Other History and Habits:**

**Family History:**

Y N U Tobacco smoking or chewing

Y N U Jaw size imbalance

Y N U Other substance abuse

Y N U Bleeding disorders

Y N U Operations

Y N U Diabetes

Y N U Hospitalizations

Y N U Arthritis

Y N U Other physical problems

Y N U Severe allergies

Y N U Are you pregnant?

Y N U Unusual dental problem

**DENTAL HISTORY:** Answer every question by circling Y (yes) N (no) U (unsure)

Now or in the past, have you had:	Describe:
Y N U Permanent or "extra" teeth removed?	
Y N U Supernumerary (extra) or congenitally missing teeth?	
Y N U Chipped or injured primary (baby) or permanent teeth?	
Y N U Teeth sensitive to hot, cold; teeth throb or ache?	
Y N U Jaw fractures, cysts or mouth infections?	
Y N U "Dead teeth" or root canals?	
Y N U Bleeding gums, bad taste or odor?	
Y N U Periodontal (gum) problems? Bleeding, odor, bad taste?	
Y N U Food impaction between teeth?	
Y N U "Gum boils", frequent cancer sores or cold sores?	
Y N U Thumb or finger sucking habit? Until what age?	
Y N U Abnormal swallowing or tongue thrust habit?	
Y N U History of speech problems?	
Y N U Mouth breathing, snoring, or difficulty breathing?	
Y N U Tooth grinding or jaw clenching?	
Y N U Pain/difficulty chewing, jaw opening, clicking or ringing in the ears?	
Y N U Have you ever been treated for "TMJ" problems or "TMD"?	
Y N U Aware of loose, broken, or missing restorations (fillings)?	
Y N U Any teeth irritating cheek, lip, tongue or palate?	
Y N U Concerned about spaced, protruding or crooked teeth?	
Y N U Aware or concerned about under or over developed jaw?	
Y N U Any relative with similar tooth or jaw relationships?	
Y N U Any wisdom tooth problems?	
Y N U Had any serious trouble associated with previous dental treatment?	
Y N U Been under another dentist's care? Specialist?	
Y N U Ever had a prior orthodontic examination or treatment?	
Y N U Would you object to wearing braces should they be indicated?	
How often do you brush your teeth?	Floss?
What is your primary concern?	

**I have read and understand the above questions. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later of this history record or medical/dental status, I will so inform the practice.**

**Signed (patient)** \_\_\_\_\_ **Date** \_\_\_\_\_

**Dr/Staff member** \_\_\_\_\_ **Date** \_\_\_\_\_