Dahlke
Orthodontics

CONFIDENTIAL

Medical Dental History Form
For Adult Patients

Date ___________________

PATIENT INFORMATION

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

Physical Street Address ____

City___________________________ State_____________ Zip code________________

Mailing Address (*if different from above*) ____

Contact Numbers: **Cell Phone** (______)_______-________ Home Phone (______)_______-__________

Employer:___________________________________ Work phone (______)_______-__________

E-mail Address____

Would you like to receive e-mails for announcements and appointment reminders from Dahlke Orthodontics? *(No solicitation)* ☐Yes ☐No

DENTAL INSURANCE

Primary policy holder's full name____ Birth Date ____ /_____ /______

Social Security # ________-______-_________ Relationship to patient ________________________

Employer____ City, State__________________________

Insurance Company ____Group # _______________ ID # _____________________

Insurance Co. Phone (_______)________-___________ Insurance Co. City, State__________________________

Does this policy have orthodontic benefits? ☐Yes ☐No ☐Don't know

Secondary policy holder's full name____ Birth Date ____ /_____ /______

Social Security # ________-______-_________ Relationship to patient ________________________

Employer____ City, State__________________________

Insurance Company ____Group # _______________ ID # _____________________

Insurance Co. Phone (_______)________-___________ Insurance Co. City, State__________________________

Does this policy have orthodontic benefits? ☐Yes ☐No ☐Don't know

EMERGENCY CONTACT

Spouse or closest relative's name (s) ____

Relationship to you________________________________Primary phone (______)______-_________

GENERAL INFORMATION

What concerns you about your teeth? ____

Whom may we thank for referring you? ____

Has any previous orthodontic treatment or consultations occurred? ☐ Yes ☐No If yes, where? _______________________

Have any other family members been treated in our office? ☐ Yes ☐No If yes, Name______________________________

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DENTIST

Patient's Dentist____ City, State ___________________________

Last date seen__________________ Reason _______________________________ Next appointment ________________

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 Any injuries to face, head, neck?
☐yes ☐no ☐dk/u Arthritis or joint problems?
☐yes ☐no ☐dk/u Endocrine or thyroid problems?
☐yes ☐no ☐dk/u Diabetes or low sugar?
☐yes ☐no ☐dk/u Kidney problems?
☐yes ☐no ☐dk/u Immune system problems?
☐yes ☐no ☐dk/u History of osteoporosis?
☐yes ☐no ☐dk/u Sexually transmitted diseases?
☐yes ☐no ☐dk/u AIDS or HIV positive?
☐yes ☐no ☐dk/u Hepatitis, jaundice or other liver problems?
☐yes ☐no ☐dk/u Polio, mononucleosis, tuberculosis, pneumonia?
☐yes ☐no ☐dk/u Seizures, fainting spells, neurologic problem?
☐yes ☐no ☐dk/u Mental health disturbance or depression?
☐yes ☐no ☐dk/u History of eating disorder (anorexia, bulimia)?
☐yes ☐no ☐dk/u Frequent headaches or migraines?
☐yes ☐no ☐dk/u High or low blood pressure?
☐yes ☐no ☐dk/u Excessive bleeding or bruising tendency, anemia?
☐yes ☐no ☐dk/u Heart defects, heart murmur, rheumatic heart disease?
☐yes ☐no ☐dk/u Angina, arteriosclerosis, stroke or heart attack?
☐yes ☐no ☐dk/u Vision, hearing, or speech problems?
☐yes ☐no ☐dk/u Asthma, sinus problems, hayfever?
☐yes ☐no ☐dk/u Cancer, tumor, radiation treatment or chemotherapy?
☐yes ☐no ☐dk/u Have you ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate), Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders or cancer?

ALLERGIES

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

☐yes ☐no ☐dk/u Latex (gloves, balloons)
☐yes ☐no ☐dk/u Local anesthetics (novocaine, lidocaine, xylocaine)
☐yes ☐no ☐dk/u Metals (jewelry, clothing snaps)
☐yes ☐no ☐dk/u Any Antibiotics (Penicillin)
☐yes ☐no ☐dk/u Plant pollens (environmental)
☐yes ☐no ☐dk/u Animals
☐yes ☐no ☐dk/u Foods
☐yes ☐no ☐dk/u Other substances ____________________

DENTAL HISTORY

Now or in the past, has the patient had:

☐yes ☐no ☐dk/u Erupting teeth very early or very late?
☐yes ☐no ☐dk/u Extra (supernumerary) teeth?
☐yes ☐no ☐dk/u Congenitally missing teeth?
☐yes ☐no ☐dk/u Chipped or injured teeth?
☐yes ☐no ☐dk/u Any missing or broken fillings?
☐yes ☐no ☐dk/u Jaw fractures, cysts, infections?
☐yes ☐no ☐dk/u Difficulty breathing through nose?
☐yes ☐no ☐dk/u Frequent oral habits (sucking finger, thumb, pacifier)?
☐yes ☐no ☐dk/u Clicking, locking in jaw joints?
☐yes ☐no ☐dk/u Tooth grinding or clenching?

PATIENT HEALTH INFORMATION

Please list any medication, nutritional or herbal supplements, non-prescription medicines, including fluoride that you take.

Medication ______________________________ Taken for____________________________

Medication ______________________________ Taken for____________________________

Women: Are you pregnant? ☐Yes ☐ No Are you trying to become pregnant? ☐Yes ☐ No

Any other medical conditions we should be aware of?____

RELEASE AND WAIVER

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 history.

I authorize release of any information regarding my orthodontic treatment to my dental insurance company. As a condition of treatment by this office, I understand financial arrangements must be made in advance. I authorize and understand a complete examination to develop an orthodontic treatment plan sometimes includes x-rays, photographs, and study models. I have read the above conditions and agree to their content.

Patient Signature ____ **Date**___________________