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Member American Association of Orthodontists

MEDICAL AND DENTAL PRELIMINARY INFORMATION — ADULT

Date _____

Patient's Name _____ (Last / First / Middle) Home Phone ( ) _____

Home Address _____ (Street)

_____ (City / State / Zip)

Age _____ Date of Birth ___/___/___ (mo / day / yr) Sex _____ Social Security # _____

Single ____ Married ____ Divorced ____ Separated ____

Employer _____ Occupation _____

Business Address _____ (Street)

_____ (City / State / Zip)

Business Phone ( ) _____

Name of Spouse _____ Date of Birth ___/___/___ (mo / day / yr)

Spouse's Employer _____ Occupation _____

Spouse's Business Phone ( ) _____ Social Security # _____

Patient's Dentist _____

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

Do you have Orthodontic Dental Insurance? ☐ Yes ☐ No

Insured Name _____

Name of Insurance Co. _____ Group No. _____

MEDICAL

	Yes	No
1. Is the patient in good health?		
2. Has there been any change in general health in the past year?		
3. Is the patient presently under a physician's care?		
4. Has the patient ever been seriously ill?		
5. Has the patient ever been hospitalized?		
6. Has the patient ever had surgery?		
7. Is the patient currently taking any medication?		
If yes, which medication?		

8. Is there any history of the following?

	Yes	No		Yes	No
Severe headaches			Heart disease		
Sinus trouble			High blood pressure		
Frequent colds			Hepatitis		
Persistent cough			Liver disease		
Tonsilitis			Kidney disorder		
Frequent sore throat			Diabetes		
Operation or injury to teeth or jaws			Endocrine disturbance		
Deviated septum of nose			Convulsions		
Allergies			Venereal disease		
(Name them) _____			Acquired Immune Deficiency		
Anemia			HIV infection		
Bleeding problem			Speech problem		
Tuberculosis			Behavioral problem		
Rheumatic fever			Emotional problem		
Any joint problems			Other		

DENTAL

9. When did the patient last see the dentist? _____

10. Is there any history of the following?

	Yes	No		Yes	No
Removal of teeth	_____	_____	Root canal work	_____	_____
Sensitive teeth	_____	_____	Oral surgery	_____	_____
Sore, bleeding gums	_____	_____	Other extensive treatment	_____	_____
Gum treatment	_____	_____			

Please explain _____

11. Is there any history of the following habits?

	Yes	No		Yes	No
Thumbsucking	_____	_____	Nail/lip biting	_____	_____
Fingersucking	_____	_____	Other	_____	_____

Please explain _____

12. Does the patient grind the teeth or clinch the jaws at night? _____ _____
    during the day? _____ _____
13. Does the patient breathe mainly through the mouth at night? _____ _____
14. Is there a clicking or popping of the lower jaw joint? _____ _____
15. Is there pain or ache of the lower jaw joint at any time? _____ _____
    If yes, please explain _____
16. Does any member of the family or close relative have a similar arrangement of teeth or appearance of jaws? _____ _____
17. Has any member of the family had orthodontic treatment? _____ _____
18. Who first noticed the need for orthodontic treatment? _____ _____
    ☐ Parent ☐ Dentist ☐ Patient ☐ Other _____
19. Why are you seeking treatment? (Check all that apply)
    ☐ Appearance ☐ Better chewing ☐ Better speech ☐ On advice from dentist ☐ On advice of friends
    ☐ Other Please explain _____
20. Is there a facial feature that you would like to alter with orthodontic therapy on yourself or on your child?

(This will be discussed confidentially if desired)	Yes	No		Yes	No
Lips	_____	_____	Gums showing when smiling	_____	_____
Nose	_____	_____	Other	_____	_____
Chin	_____	_____			

Signature (Parent's signature if minor) _____

Updates (date & initial) _____