Orthodontics
Adult Health History

Dental History

Dentist ______________________ Date of last dental examination ______________

- ◯ Yes ◯ No Have there been any injuries to the face, mouth or teeth?
- ◯ Yes ◯ No Are you or have you been made aware of clenching or grinding your teeth?
- ◯ Yes ◯ No Do your jaw joints make clicking, popping or grating sounds?
- ◯ Yes ◯ No Do you have chronic headaches or neck and shoulder pain?
- ◯ Yes ◯ No Do you have now or have you ever had pain in your jaw joints or in the side of your face or around your ears?
- ◯ Yes ◯ No Do you have missing teeth?
- ◯ Yes ◯ No Do you have extensive bridges or crowns?
- ◯ Yes ◯ No Have you ever had gum disease?
- ◯ Yes ◯ No Have you or any member of your family had orthodontic treatment?
  If yes, please explain ______________________
- ◯ Yes ◯ No Have you worn a splint before? ______________________

How often do you brush your teeth? ◯ Several times a day ◯ Twice a day ◯ Once a day ◯ Occasionally

Medical History

Physician ______________________

Do you have any history of major illness? ◯ No ◯ Yes

If yes, please explain. ______________________

Are you currently under the care of a physician for any medical conditions? ◯ No ◯ Yes

If yes, please explain. ______________________

Place a check beside the medical conditions which the patient has now or had previously.

◯ AIDS/HIV	◯ Cerebral Palsy	◯ Heart disorders	◯ Nervous disorders
◯ Anemia	◯ Glaucoma	◯ Heart murmur	◯ Pneumonia
◯ Arthritis	◯ Cold sores/oral ulcers	◯ Hepatitis	◯ Rheumatic Fever
◯ Asthma	◯ Diabetes	◯ High blood pressure	◯ Sleep Apnea
◯ Bleeding disorders	◯ Endocrine disorders	◯ Joint Replacement	◯ Thyroid
◯ Bone disorders	◯ Epilepsy	◯ Kidney disease	◯ Tuberculosis
◯ Cancer	◯ Hearing Problems	◯ Lung disorders	◯ Other ________

Please comment on any checked above. ______________________

Do you smoke or chew tobacco? ◯ No ◯ Yes

Do you have any allergies or drug sensitivities? ◯ No ◯ Yes ______________________

Do you have a nickel allergy? ◯ No ◯ Yes

Have you ever been told you needed antibiotics before having dental work performed? ◯ No ◯ Yes

Please list all medications you are presently taking. ______________________

____

Authorization & Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and /or health practitioners. I agree to be responsible for payment of all services. I understand that when necessary credit information may be obtained.

Patient Signature ______________________