My Life. My Smile. My Orthodontist.

CONFIDENTIAL

SCHUESSLER ORTHODONTICS

Medical Dental History Form for Adult Patients

Date:

Patient

Patient's Last Name: _____ First Name: _____ Middle Initial _____

Title Mr. Mrs. Ms. Miss. Dr. Other: _____ I prefer to be called: _____

Birth Date: _____ Age _____ Sex Male ◯ Female ◯ SSN # _____

Marital Status ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed ◯ Partnered

Home Address _____ City, State, Zip Code _____

Home Phone: ( ) - Cell Phone: ( ) - Work Phone: ( ) -

Email Address(es) : _____

Occupation: _____ Employer: _____

Closest Relative

Spouse or Closest Relative's Name(s) _____

Title Mr. Mrs. Ms. Miss. Dr. Other: _____ Relationship to Patient: _____

Address (if different from patient) _____

Home Phone: ( ) - Cell Phone: ( ) - Work Phone: ( ) -

Dentist

Patient's Dentist: _____ Address, City, State _____

Last Seen _____ Reason _____ Next Appointment _____

Other Dentist/Dental Specialist now being seen: Name: _____ City, State _____

Reason: _____

Physician

Patient's Physician: _____ City, State _____

Last Seen _____ Reason _____ Next Appointment _____

Other Physician/Health Care Provider: Name: _____ City, State _____

Reason: _____

Other Physician/Health Care Provider: Name: _____ City, State _____

Reason: _____

General Information

What concerns you about your teeth? _____

Who suggested that you might need orthodontic treatment? _____

Why did you select our office? _____

Have you had any previous orthodontic treatment? Please describe. _____

Have any other family members been treated In this office? Please name them. _____

_____

Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain. _____

_____

Financial Responsibility

Who is financially responsible for this account? _____

Address (if different than page 1) _____ City, State, Zip Code _____

Home Phone: ( ) - _____ Cell Phone: ( ) - _____ Work Phone: ( ) - _____

Email Address(es): _____

Occupation: _____ Employer: _____

Dental Insurance

Primary Policy Holder's Full Name: _____ Birth date: _____

Social Security # _____ Relationship to Patient: _____

Address (if different than page 1) _____ City, State, Zip Code _____

Home Phone: ( ) - _____ Cell Phone: ( ) - _____ Work Phone: ( ) - _____

Employer: _____ Address: _____

Insurance Company: _____ Group #: _____ ID#: _____

Does this policy have orthodontic benefits? ◯ Yes ◯ No ◯ Don't Know - Please find out my benefit for me.

Secondary Policy Holder's Full Name: _____ Birth Date: _____

Social Security # _____ Relationship to Patient: _____

Address (if different than page 1) _____ City, State, Zip Code _____

Home Phone: ( ) - _____ Cell Phone: ( ) - _____ Work Phone: ( ) - _____

Employer: _____ Address: _____

Insurance Company: _____ Group #: _____ ID#: _____

Does this policy have orthodontic benefits? ◯ Yes ◯ No ◯ Don't Know - Please find out my benefit for me.

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation. 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
Birth defects or hereditary problems?			
Bone Fractures or major injuries?			
Any injuries to face, head, neck?			
Arthritis or joint problems?			
Endocrine or thyroid problems?			
Diabetes or low sugar?			
Kidney problems?			
Cancer, tumor, radiation treatment or chemotherapy?			
Immune system problems?			
History of osteoporosis?			
Gonorrhea, syphilis, herpes, sexually transmitted diseases?			
AIDS or HIV positive?			
Hepatitis, jaundice, or other liver problems?			
Polio, mononucleosis, tuberculosis, pneumonia?			
Seizures, fainting spells, neurologic problems?			
Mental health disturbance or depression?			
Vision, hearing, or speech problems?			
History of eating disorder (anorexia, bulimia)?			
Frequent headaches or migraines?			
High or low blood pressure?			
Excessive bleeding or bruising, anemia?			
Chest pain, shortness of breath, tire easily, swollen ankles?			
Heart defects, heart murmur, rheumatic heart disease?			
Angina, arteriosclerosis, stroke, or heart attack?			
Skin disorder (other than common acne)?			
Do you eat a well-balanced diet?			
Frequent ear infections, colds, throat infections?			
Asthma, sinus problems, hay fever?			
Tonsil or adenoid condition?			
Do you frequently breathe through your mouth?			
Have you ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?			
Have you ever taken oral bisphosphonates such as Fosamax (alendronate), Actone (ridendronate), Boniva (ibandronated), Skelid (tiludronte), or Didronel (etidronate) for bone disorders?			

Have you had allergies or reactions to any of the following?	Yes	No	DK/U
Local anesthetics (novocaine, lidocaine)			
Latex (gloves, balloons)			
Aspirin			
Metals (jewelry, clothing snaps)			
Penicillin			
Other antibiotics			
Ibuprofen (Motrin, Advil)			
Acrylics			
Plant pollens			
Animals			
Foods			
Other substances			

Dental History

Now or in the past, have you had:	Yes	No	DK/U
Permanent or extra (supernumerary) teeth removed?			
Supernumerary (extra) or congenitally missing teeth?			
Chipped or injured primary or permanent teeth?			
Any sensitive or sore teeth?			
Bleeding rums, bad taste or mouth odor?			
Any lost or broken fillings?			
Jaw fractures, cysts, infections?			
Any teeth treated with root canals or pulpotomies?			
Frequent canker sores or cold sores?			
History of speech problems or speech therapy?			
Difficulty breathing through nose?			
Food impaction between teeth?			
Mouth breathing habit or snoring at night?			
Frequent oral habits (sucking finger, chewing lip, etc)?			
Teeth causing irritation to lip, cheek, or gums?			
Tooth grinding or clenching			
Clicking, locking in jaw joints			
Soreness in jaw muscles or face muscles?			
Ringing in ears, difficulty in chewing or opening jaw?			
Have you ever been treated for TMJ or TMD symptoms?			
Have you ever been diagnosed with gum disease?			
Have you ever had an orthodontic consultation before?			
Have you had previous orthodontic treatment?			
If so when?			

Patient Health Information

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

Medication: _____ Taken for: _____
Medication: _____ Taken for: _____
Medication: _____ Taken for: _____

Have you ever taken medications to strengthen your bones? Please describe: _____

Do you take antibiotic pre-medication before any dental procedures? _____

Do you or have you ever had a substance abuse problem? _____

Do you chew or smoke tobacco? _____

Have you noticed any changes in your face or jaws? _____ Any other physical problems? _____

How often do you brush? _____ How often do you floss? _____

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

Family Medical History

Have your parents or siblings ever had any of the following health problems? If so, please explain.

_____

_____

Bleeding Disorders: _____ Diabetes: _____

Arthritis: _____ Severe Allergies: _____

Unusual Dental Problems: _____ Jaw Size Imbalance: _____

Other Family Medical Conditions? _____

Release and Waiver

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature: _____ Date: _____

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.

Signature: _____ Date: _____

Medical History Update or Changes

Changes: _____
Signature: _____ Date: _____
Dental Staff Signature: _____ Date: _____