

SmartSmiles Orthodontics – 315 Ray Thorington Rd. Montgomery, AL 36117 - www.SmartSmiles.com
American Association of Orthodontists MEDICAL DENTAL HISTORY FORM – Adult

Date _____
Patient's Last Name _____ First _____ Middle _____
Birthdate _____ Age _____ Sex : Male Female I prefer to be called _____
Home Phone _____ Cell Phone _____ Email Address _____
Patient's Address – Street _____
City _____ State _____ Zip Code _____
Patient is: Single Married Widowed Separated Divorced
Occupation _____ Social Security No. _____ Business Phone No _____
Name of Spouse/closest relative _____ Phone No (if different from patient) _____
Address (if different from patient) _____ City _____ State _____ Zip _____
Name of Dentist _____ Phone _____
Name of Physician(s) _____ Phone _____
Who suggested you might need orthodontic treatment? _____
Referred by: / Why did you select our office? _____
Who is financially responsible for account? Name _____ Phone Number _____
Address _____
Insurance coverage: yes no
Primary Insurance Co. _____ Policy# _____ Group # _____
Primary Policy Holder: Name _____ SSN / SIN _____ Birth Date _____
Secondary Insurance Co. _____ Policy# _____ Group # _____
Secondary Policy Holder: Name _____ SSN / SIN _____ Birth Date _____
In case we cannot reach you: Person to contact _____ Phone _____
Present Weight _____ Height _____ Musical Instrument Played _____
Favorite Sports, Hobbies, & Avocations _____

For the following questions circle **yes, no or don't know/understand (dk/u)**. The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

MEDICAL HISTORY Now or in the past, have you had:

yes no dk/u Birth defects or hereditary problems?	yes no dk/u Vision, hearing, tasting or speech difficulties?
yes no dk/u Bone fractures, any major accidents?	yes no dk/u Loss of weight recently, poor appetite?
yes no dk/u Rheumatoid or arthritic conditions?	yes no dk/u History of eating disorder (anorexia, bulimia)?
yes no dk/u Endocrine or thyroid problems	yes no dk/u Excessive bleeding, bruising tendency, anemia or bleeding disorder?
yes no dk/u Kidney problems?	yes no dk/u High or low blood pressure?
yes no dk/u Diabetes?	yes no dk/u Tired easily?
yes no dk/u Cancer, tumor, radiation treatment or chemotherapy?	yes no dk/u Chest pain, shortness of breath or swelling ankles?
yes no dk/u Stomach ulcer or hyperacidity?	yes no dk/u Cardiovascular problems (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects or rheumatic heart disease)?
yes no dk/u Polio, mononucleosis, tuberculosis, pneumonia?	yes no dk/u Skin disorder?
yes no dk/u Problems of the immune system?	yes no dk/u Do you have a well-balanced diet?
yes no dk/u AIDS or HIV positive?	yes no dk/u Frequent headaches, colds or sore throat?
yes no dk/u Hepatitis, jaundice, or liver problem?	
yes no dk/u Fainting spells, seizures, epilepsy or neurological problem?	
yes no dk/u Mental health disturbance or depression?	

yes no dk/u Eye, ear, nose, throat condition?
yes no dk/u Hayfever, asthma, sinus trouble or hives?
yes no dk/u Tonsil, or adenoid conditions?
yes no dk/u Osteoporosis?

Allergies or reactions to any of the following:

yes no dk/u Local anesthetics (Novocaine or Lidocaine)
yes no dk/u Aspirin
yes no dk/u Ibuprofen (Motrin, Advil)
yes no dk/u Penicillin or other antibiotics
yes no dk/u Sulfa drugs
yes no dk/u Codeine or other narcotics
yes no dk/u Metals (jewelry, clothing snaps)
yes no dk/u Latex (gloves, balloons)
yes no dk/u Vinyl
yes no dk/u Acrylic
yes no dk/u Animals
yes no dk/u Foods (specify) _____
yes no dk/u Other substances (specify) _____

yes no dk/u Are you taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.

Medication: _____

Taken For: _____

Medication: _____

Taken For: _____

Medication: _____

Taken For: _____

Medication: _____

Taken For: _____

yes no dk/u Do you currently have or ever had a substance abuse problem?

yes no dk/u Do you smoke or chew tobacco?

yes no dk/u Operations? Describe: _____

yes no dk/u Hospitalized? For: _____

yes no dk/u Other physical problems or symptoms?
Describe: _____

yes no dk/u Being treated by another health care professional?
For: _____

Date of most recent physical exam?: _____

Do you have any other medical conditions we should know about?

What is your primary concern? Why are you here? _____

I have read and understand the above questions. 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. If there are any changes later to this history record or medical / dental status, I will so inform this practice.

Signature of patient: _____ Date Signed: _____

Signature of dental staff member: _____ Date Signed: _____

Women Only

yes no dk/u Are you pregnant?
yes no dk/u Are you anticipating becoming pregnant?

DENTAL HISTORY Now or in the past, has the patient had:

yes no dk/u Permanent or "extra" (supernumerary) teeth removed?
yes no dk/u Supernumerary (extra) or congenitally missing teeth?
yes no dk/u Chipped or otherwise injured primary (baby) or permanent teeth?
yes no dk/u Teeth sensitive to hot or cold; teeth throb or ache?
yes no dk/u Jaw fractures, cysts, mouth infections?
yes no dk/u "Dead Teeth", root canals treated?
yes no dk/u Bleeding gums, bad taste, mouth odor?
yes no dk/u Periodontal "Gum Problems"?
yes no dk/u Food impaction between teeth?
yes no dk/u "Gum Boils", frequent canker sores, cold sores?
yes no dk/u Thumb, finger, sucking habit? Until what age? _____
yes no dk/u Abnormal swallowing habit (tongue thrusting)?
yes no dk/u History of speech problems?
yes no dk/u Mouth breathing habit, snoring, difficulty in breathing?
yes no dk/u Tooth grinding, jaw clenching?
yes no dk/u Any pain, clicking or locking in jaw or ringing in the ears?
yes no dk/u Any pain or soreness in the muscles of the face, or around the ears?
yes no dk/u Difficulty in chewing or jaw opening?
yes no dk/u Have you ever been treated for "TMD" or "TMJ" problems?
yes no dk/u Aware of loose, broken, or missing restorations (fillings)?
yes no dk/u Any teeth irritating cheek, lip, tongue or palate?
yes no dk/u Concerned about spaced, crooked or protruding teeth?
yes no dk/u Aware or concerned about under or over developed jaw?
yes no dk/u Any relative with similar tooth or jaw relationships?
yes no dk/u Any wisdom tooth problems?
yes no dk/u Had periodontal (gum) treatment?
yes no dk/u Have you ever had any serious trouble associated with any previous dental treatment?
yes no dk/u Been under another dentist's care?
Specialist: _____ Other: _____
yes no dk/u Ever had a prior orthodontic examination or treatment?
yes no dk/u Would you object to wearing orthodontic appliances (braces) should they be indicated?
How often do you brush: _____ Floss: _____