



# NORTH POTOMAC ORTHODONTICS

## ADULT MEDICAL DENTAL HISTORY FORM

All information provided is confidential, protected by law, and used solely for medical care purposes. We will not disclose your data without your consent, except as legally required.

### PATIENT

Today's date \_\_\_\_\_

Last name \_\_\_\_\_

First name \_\_\_\_\_ M.I. \_\_\_\_\_

Title: Mr. Mrs. Miss Dr. Other: \_\_\_\_\_

Preferred to be called \_\_\_\_\_

Birth date \_\_\_\_\_

Social security # \_\_\_\_\_

Assigned Sex: Male Female

Gender Identification: Male Female Other: \_\_\_\_\_

Preferred pronouns \_\_\_\_\_

Home address \_\_\_\_\_

City, State, Zip code \_\_\_\_\_

Cell phone # \_\_\_\_\_

Work phone # \_\_\_\_\_

Email address \_\_\_\_\_

Marital status: Single Married Divorced

Separated Widowed

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

### EMERGENCY CONTACT

Full name \_\_\_\_\_

Address (if different) \_\_\_\_\_

Cell phone # \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Email address \_\_\_\_\_

### DENTAL INSURANCE

#### Primary Policy

Insurance company \_\_\_\_\_

Subscriber name \_\_\_\_\_

Subscriber birth date \_\_\_\_\_

Subscriber SSN \_\_\_\_\_

Member ID # \_\_\_\_\_

Group # \_\_\_\_\_

Employer \_\_\_\_\_

#### Secondary Policy

Insurance company \_\_\_\_\_

Subscriber name \_\_\_\_\_

Subscriber birth date \_\_\_\_\_

Subscriber SSN \_\_\_\_\_

Member ID # \_\_\_\_\_

Group # \_\_\_\_\_

Employer \_\_\_\_\_

### DENTAL HISTORY

General Dentist \_\_\_\_\_

Other dentist \_\_\_\_\_

How often do you brush? \_\_\_\_\_

Last visit \_\_\_\_\_

How often do you floss? \_\_\_\_\_

How did you hear about our practice? Doctor Family or Friend Ad Internet Other

Name of person referring (if applicable) \_\_\_\_\_

Do you like your smile? Y N

Main concerns you would like orthodontics to accomplish? \_\_\_\_\_

Have you visited an orthodontist before? Y N

When? \_\_\_\_\_ Reason? \_\_\_\_\_

Have we treated any other family members? Y N

If yes, please name \_\_\_\_\_

**Now or in the past, have you had:**

- |  |   |
|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Previous orthodontic treatment?      | <input type="checkbox"/> Y <input type="checkbox"/> N Frequent habit of thumb/finger sucking? |
| <input type="checkbox"/> Y <input type="checkbox"/> N Permanent or extra teeth removed?    | <input type="checkbox"/> Y <input type="checkbox"/> N Mouth breathing habit or snoring?       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Tonsils or adenoids removed?         | <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums, bad taste or mouth odor? |
| <input type="checkbox"/> Y <input type="checkbox"/> N Missing or extra permanent teeth?    | <input type="checkbox"/> Y <input type="checkbox"/> N Smoking habit?                          |
| <input type="checkbox"/> Y <input type="checkbox"/> N Injury to the mouth, teeth, or chin? | <input type="checkbox"/> Y <input type="checkbox"/> N Been diagnosed with gum disease?        |
| <input type="checkbox"/> Y <input type="checkbox"/> N History of speech problems?          | <input type="checkbox"/> Y <input type="checkbox"/> N "TMJ" or "TMD" problems?                |
| <input type="checkbox"/> Y <input type="checkbox"/> N Frequent habit of nail biting?       | <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal swallowing (tongue thrust)?    |

**MEDICAL HISTORY**

Patient's Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Last visit \_\_\_\_\_ Reason \_\_\_\_\_

Do you have any diagnosed or suspected emotional, sensory, or developmental conditions? Y N

If yes, please describe \_\_\_\_\_

Do you have any allergies/sensitivities to medications, metal, or latex? Y N

If yes, please list \_\_\_\_\_

Are you currently taking any prescription or over-the-counter medication? Y N

If yes, please list (with dosage) \_\_\_\_\_

Have you had any serious illnesses or operations? Y N

If yes, please describe \_\_\_\_\_

Have you had a blood transfusion? Y N

If yes, give approximate dates \_\_\_\_\_

Have you ever taken intravenous bisphosphonates such as Zometa (zoledronic acid), Aredia (pamidronate), or Didronel (etidronate)? Y N

Have you ever taken oral medication for bone disorders or cancers such as bisphosphonates such as Fosamax (alendronate), Actonel (risedronate), Boniva (ibandronate), Skelid (tiludronate), or Didronel (etidronate)? Y N

FOR WOMEN (select all that apply): Pregnant Nursing Taking birth control pills

**Now or in the past, have you had (select all that apply):**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> ADHD                     | <input type="checkbox"/> Chemotherapy         | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Respiratory Disease    |
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Rheumatic Fever        |
| <input type="checkbox"/> Anxiety                  | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Scarlet Fever          |
| <input type="checkbox"/> Arthritis, Rheumatism    | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Shortness of Breath    |
| <input type="checkbox"/> Artificial Heart Valves  | <input type="checkbox"/> Coughing Blood       | <input type="checkbox"/> High Cholesterol     | <input type="checkbox"/> Skin Rash              |
| <input type="checkbox"/> Artificial Joints        | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> HIV/AIDS             | <input type="checkbox"/> Stroke                 |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Depression           | <input type="checkbox"/> Jaw Pain             | <input type="checkbox"/> Swelling of Feet/Ankle |
| <input type="checkbox"/> Autism Syndrome Disorder | <input type="checkbox"/> Eating Disorder      | <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Thyroid Problems       |
| <input type="checkbox"/> Autoimmune Disease       | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Tobacco Habit          |
| <input type="checkbox"/> Back Problems            | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Mital Valve Prolapse | <input type="checkbox"/> Tonsillitis            |
| <input type="checkbox"/> Blood Disease            | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Tuberculosis           |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Headaches/Migraines  | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Ulcer                  |
| <input type="checkbox"/> Chemical Dependency      | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Radiation Treatment  | <input type="checkbox"/> Venereal Disease (STD) |

**AUTHORIZATION**

I have read the above questions and understand them. The above questions have been accurately answered. 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 understand that it is my responsibility to notify my orthodontist of any changes in my medical or dental health.

I authorize the release of any information regarding my orthodontic treatment to my dental and/or medical insurance company. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_