SEYMOUR ORTHODONTICS

Medical and Dental History for Adult Patients

Patients Last Name:_____First name:_____Middle initial____Prefers to be called:_____ Date of birth:_____Age:_____Gender:_____
Address:_____City:_____Sate_____Zip:_____
Phone #:(home)_____ Patients mobile:_____Office:_____
Any family treated here?_____
For Office communication:
Email_____Mobile#_____
**Who is financially responsible for this patient's account? Last name:_____First:_____
Address (if different):_____
City:_____State:_____Zip:_____Phone #:_____ Employer:_____Job title:_____ Insurance information: Primary policy holder's: Last name:_____First_____MI:_____
Address(if different than patient's):_____
City_____State:_____Zip:_____Phone #:_____
SS#:_____DOB:_____Employed by:_____ Dental insurance company:_____Group #:_____ Secondary policy holder's: Last name:_____First:_____MI:_____ Address(if different):_____
City_____State:_____Zip:_____Phone #:_____
SS#:_____DOB:_____Employed by:_____
Dental insurance company:_____Group #:_____

How did you hear about our office?_____
General dentist's name:_____ City:_____State:_____
Date of patients last cleaning_____Frequency of Cleanings: 3 months 4 months 6 months
Physician's name:_____City:_____State:_____

For the following questions, please mark yes (Y) or no (N). These answers are for office records only and are confidential. A thorough medical history is necessary for a proper orthodontic evaluation.
MEDICAL HISTORY Now or in the past have you had:
Y N Learning disabilities or need extra help with instructions?
Y N ADD or ADHD?
Y N Birth defects or hereditary problems?
Y N Was the patient adopted?
Y N Rheumatoid or arthritic conditions?
Y N Endocrine or thyroid problems?
Y N Diabetes?
Y N Cancer, tumor, radiation treatments, or chemotherapy?
Y N Acid reflux?
Y N Tuberculosis, polio, mononucleosis, or pneumonia?
Y N Problems of the immune system?
Y N HIV or AIDS?
Y N Hepatitis, jaundice, or liver problems?
Y N Seizures, Epilepsy, Fainting spells, or neurological problems?
Y N Mental health disturbance or depression?
Y N Vision, hearing, taste, or speech difficulties?
Y N History of eating disorder, anorexia or bulimia?
Y N Excessive bleeding or bruising tendency, anemia, or bleeding disorder?
Y N High or low blood pressure?
Y N Cardiovascular problems such as shortness of breath, angina, heart attack?
Y N Heart murmur, rheumatic fever, inborn heart defect, artificial heart valves?
Y N Allergies or asthma?

Y N Ear, nose, throat, tonsil or adenoid conditions?

(Continue on other side)

Allergies or reactions to any of the following:

Y N Aspirin or Ibuprofen?
Y N Penicillin or other antibiotic?
Y N Codeine or other narcotics?
Y N Metals?
Y N Latex?
Y N Other substances:_____ **Please list any medications, nutrient supplements, herbal medications, or non-prescription medicine you are currently taking:**
Y N Do you currently have or ever had a substance abuse problem?
Y N Do you chew or smoke tobacco?
Y N Please list any operations or hospitalizations:_____
Y N Being treated by another health care professional? For_____

For Women Only:

Y N Has menstruation begun? When?_____
Y N Are you pregnant?

DENTAL HISTORY Now or in the past have you had:

Y N Extra or supernumerary teeth?
Y N Congenitally missing teeth or any permanent teeth removed?
Y N Early loss of baby teeth due to decay or trauma?
Y N Trauma or injury to baby or permanent teeth?
Y N Jaw fractures, cysts, or mouth infections?
Y N Periodontal or gum problems?
Y N Thumb or finger sucking habit? Until what age?_____
Y N Tongue thrusting?
Y N History of speech problems?
Y N Mouth breathing habit?
Y N Tooth grinding, jaw clenching, clicking or locking, or other problems of the TMJ?
Y N Any pain in the jaw or jace, ringing in the ears, or severe headaches?
Y N Frequent canker sores or cold sores?
Y Nany relative with similar tooth or jaw relationships?
Y N Any relative with jaw size imbalance?
Y N Ever had prior orthodontic examination or treatment?
Y N Is there anything you would like to discuss with the doctor in private?

I have read and understand the above questions. I will not hold Seymour Orthodontics 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 inform this practice.

Signed:_____
Date:_____ (Patient)

Signed:_____
Date:_____ (Dental Staff member)

MEDICAL HISTORY UPDATE OR CHANGES

COMMENTS:_____
_ Signed:_____ Date:_____
(Patient)

Signed:_____
Date:_____ (Dental staff member)