

CONFIDENTIAL

Lawrence R. Siegel, D.D.S. Molly A. Siegel, D.D.S. MEDICAL DENTAL HISTORY FORM FOR ADULT PATIENTS

Date		
Patient's Last Name	First	Middle
BirthdateAgeSex	Home Phone	Cell
Marital StatusAddress-Street		
City	State	Zip
Name of spouse/closest relative		Phone number
His/Her address	City	StateZip
Name of dentist		
Referred by		
Name of physician		
		Work phone number
Dental insurance coverage yes	no	
Primary Dental Insurance Co		ID number
Secondary Dental Insurance Co		ID number
In case we cannot reach you:		
Person to contact	Phone	Relationship

For the following questions circle yes, no, or do not 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	yes no dk/u	Endocrine or thyroid problems?
yes no dk/u Birth defects or heredity problems?	yes no dk/u	Kidney problems?
yes no dk/u Bone fractures, any major accidents?	yes no dk/u	Diabetes?
yes no dk/u Rheumatoid or arthritic conditions?	yes no dk/u	Cancer or been treated for a tumor?
yes no dk/u Sexually transmitted disease?	yes no dk/u	Stomach ulcer or hyperacidity?
yes no dk/u Mental health or behavioral problem?	yes no dk/u	Polio, mono, tuberculosis, pneumonia?
yes no dk/u Vision, hearing, tasting or speech difficulties?	yes no dk/u	Problems of the immune system?
yes no dk/u Loss of weight recently, poor appetite?	yes no dk/u	AIDS or HIV positive?
yes no dk/u Excessive bleeding, black and blue tendency, anemia	yes no dk/u	Hepatitis, jaundice or liver problem?
or bleeding disorders?	yes no dk/u	Fainting spells, seizures, epilepsy or neurological disease?
yes no dk/u High or low blood pressure?	yes no dk/u	Cardiovascular problem (heart trouble, heart attack,
yes no dk/u Tires easily?		angina, coronary insufficiency, arteriosclerosis,
yes no dk/u Chest pain, shortness of breath or swelling ankles?		stroke, inborn heart defects or rheumatic heart)?

yes no dk/u Skin disorder?

yes no dk/u Do you have a normal and good diet?

yes no dk/u Frequent headaches, colds or sore throats?

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

yes no dk/u Allergies or drug reactions?___

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

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

yes no dk/u Operations?

yes no dk/u Hospitalized for____

- yes no dk/u Other physical problems or symptoms?
- yes no dk/u Being treated by another health care professional? For
- yes no dk/u Are you in good health? Date of most recent physical exam

Female Patient

yes no dk/u Are you pregnant?

yes no dk/u Are you taking birth control pills?

yes no dk/u Are you anticipating becoming pregnant?

DENTAL HISTORY

- yes no dk/u Chipped or otherwise injured primary 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____
- 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 breathing?
- yes no dk/u Tooth grinding, jaw clenching, clicking or locking?
- yes no dk/u Do you experience any pain or soreness in the muscles of your face, or around the ears?
- yes no dk/u Any jaw pain or ringing in the ears?
- yes no dk/u Have you ever been treated for "TMJ" problems (Your jaw joint and facial muscle pain?)
- yes no dk/u Difficulty encountered in chewing or jaw opening?

yes no dk/u History of supernumerary (extra) or congenitally missing teeth?

yes no dk/u Have any permanent teeth been removed?

- yes no dk/u Aware of loose, broken or missing restoration (fillings)?
- yes no dk/u Any teeth irritating cheek, lip, tongue, palate?
- yes no dk/u Concerned about spaced, crooked, protruding teeth?
- yes no dk/u Aware or concerned about under or over developed jaw?
- yes no dk/u Any relative with similar tooth of jaw relationships?
- yes no dk/u Any wisdom tooth problem?
- yes no dk/u Have you ever had any serious trouble associated with any previous dental treatment?
- yes no dk/u Have you ever had Orthodontic treatment or worn a retainer or bite plate?
- yes no dk/u Are you under another dentist's care? Specialist

yes no dk/u Have you ever had periodontal (gum) treatment?
Date of most recent dental examination?
How often do you brush?
Floss?

What is your primary concern - why are you here?_____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment?

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