CONFIDENTIAL

SMAHA ORTHODONTIC Specialists

Medical Dental History Form For Adults

Date _____

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

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss. ☐ Dr. ☐ Other _____ Birthdate _____ Age _____

☐ Male ☐ Female I prefer to be called _____ Your Primary Dentist _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Mobile Phone _____

Are you the Financial Responsible Party? *YES / NO (please ask for "young adult form")* Social Security Number _____

Email Address _____ Employed by _____

Your Primary Physician _____ Who referred you to our office _____

Marital Status: ☐ Single ☐ Married ☐ Divorced Spouse Name _____ Spouse Occupation _____

Please check "yes" or "no" for all of the following medical questions

Are you in good health .....Yes ☐ No ☐
Do you have diabetes .....Yes ☐ No ☐
Birth defect/hereditary problem..Yes ☐ No ☐
Arthritis or joint problems.....Yes ☐ No ☐
History of osteoporosis.....Yes ☐ No ☐
Tonsil or adenoid condition.....Yes ☐ No ☐
Missing or Extra teeth.....Yes ☐ No ☐
Chipped or injured teeth.....Yes ☐ No ☐
Family History of Jaw Surgery...Yes ☐ No ☐

History of any jaw injury.....Yes ☐ No ☐
Sleep with mouth open.....Yes ☐ No ☐
Mouth breath during day.....Yes ☐ No ☐
Breathing trouble.....Yes ☐ No ☐
Finger habit (thumb sucking)...Yes ☐ No ☐
Tongue habit.....Yes ☐ No ☐
Teeth grinding or clinching .....Yes ☐ No ☐
Clicking or popping jaw.....Yes ☐ No ☐
Tobacco use.....Yes ☐ No ☐

Heart trouble.....Yes ☐ No ☐
Rheumatic Fever.....Yes ☐ No ☐
Prosthetic Limb.....Yes ☐ No ☐
Heart Murmur.....Yes ☐ No ☐
Allergy to metal.....Yes ☐ No ☐
Herpes/syphilis/gonorrhea...Yes ☐ No ☐
AIDS or HIV positive.....Yes ☐ No ☐
Hepatitis A,B,or C.....Yes ☐ No ☐
Latex Sensitivity.....Yes ☐ No ☐

Please list all medications you are currently taking _____

List Any Allergies or Drug Sensitivities _____

Please list any treatments you have had by a doctor in the last year _____

Do you have any problems with Clicking, Popping or Pain in the Jaw Joint? _____

Have you had any injuries or surgery to the Face, Mouth, or Teeth? _____

Do you have any Speech Problems? _____

Are you missing any permenant teeth? _____

Do you have or have you ever had problems with your Gums? _____

Has an Orthodontist been consulted previously? _____

Have you ever had Orthodontic treatment? _____

Has anyone in your family had treatment in our office? _____

What is your primary reason for getting an orthodontic cosult? _____

Responsible party's name, address, and phone number _____

_____

Patient's Signature