

# Patient Medical History Form



## PATIENT INFORMATION

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street City State Zip

Home Phone: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

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

How did you hear about our office? \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION

Name: \_\_\_\_\_  
Last First Middle Marital Status

Residence: \_\_\_\_\_  
Street City State Zip

Mailing address: \_\_\_\_\_  
Street City State Zip

How long at this address? \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Previous Address (If less than 3 years): \_\_\_\_\_  
Street City State Zip

SS#: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ No. Years Employed: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Last First Middle

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ No. Years Employed: \_\_\_\_\_

SS#: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## INSURANCE INFORMATION

Insured's Name: \_\_\_\_\_ Insured's SS or ID#: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Group #: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_  
Street City State Zip

Insured's Employer: \_\_\_\_\_

Do you have dual coverage? Yes No If yes:

Insured's Name: \_\_\_\_\_ Insured's SS#: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Group #: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_  
Street City State Zip

Insured's Employer: \_\_\_\_\_

## EMERGENCY INFORMATION

Name of nearest relative not living with you: \_\_\_\_\_

Complete Address \_\_\_\_\_  
Street City State Zip

Phone: \_\_\_\_\_

Initials: \_\_\_\_\_

## MEDICAL HISTORY

Do you have a personal physician? Y N  
 Physician's Name: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Date of last visit: \_\_\_\_\_  
 Your current physical health is:    Good      Fair      Poor  
 Are you currently under the care of a physician: Y N  
 If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you taking any prescription/over-the-counter drugs? Y N  
 If yes, please list each one: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever had any of the following diseases or medical problems?

Anemia	Y	N	Heart Surgery/Pacemaker	Y	N
Arthritis	Y	N	Hemophilia/Abnormal	Y	N
Artificial Bones/Joints	Y	N	Bleeding	Y	N
Artificial Valves	Y	N	Hepatitis	Y	N
Asthma	Y	N	High/Low Blood Pressure	Y	N
Blood Transfusion	Y	N	HIV+/AIDS	Y	N
Cancer/Chemotherapy	Y	N	Hospitalized (any reason)	Y	N
Congenital Heart Defect	Y	N	Kidney Problems	Y	N
Diabetes	Y	N	Mitral Valve Prolapse	Y	N
Difficulty Breathing	Y	N	Psychiatric Treatment	Y	N
Drug/Alcohol Abuse	Y	N	Radiation Therapy	Y	N
Emphysema	Y	N	Rheumatic/Scarlet Fever	Y	N
Glaucoma	Y	N	Shingles	Y	N
Epilepsy/Seizures	Y	N	Sinus Problems	Y	N
Fainting Spells	Y	N	Tuberculosis (TB)	Y	N
Fever Blisters/Cold Sores	Y	N	Ulcer/Colitis	Y	N
Heart Attack/Stroke	Y	N	Venereal Disease (STD)	Y	N
Heart Murmur	Y	N			

Please list any serious medical condition(s) that you have ever had: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please discuss any other concerns: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature (Parent/Guardian if minor): \_\_\_\_\_ Date: \_\_\_\_\_

Updates (dates/initial): \_\_\_\_\_

Reviewed: \_\_\_\_\_ Date: \_\_\_\_\_

Are you allergic to any of the following?:

Aspirin	Y	N	Latex	Y	N
Any metals or plastics	Y	N	Penicillin	Y	N
Codeine	Y	N	Tetracycline	Y	N
Dental Anesthetics	Y	N	Other	Y	N
Erythromycin	Y	N			

Please list any other drugs/materials you are allergic to: \_\_\_\_\_

\_\_\_\_\_

*For Women:* Are you taking birth control pills? Y N  
 Are you pregnant? Y N  
 If yes, Week #: \_\_\_\_\_  
 Are you nursing? Y N

## DENTAL HISTORY

Do you currently have a general dentist? Y N  
 How long has it been since your last dental check-up? \_\_\_\_\_  
(Months)

What are the main concerns you would like orthodontics to accomplish? \_\_\_\_\_

\_\_\_\_\_

Have you ever been evaluated for orthodontic treatment? Y N  
 Have you ever had a difficult problem associated with any previous dental work? Y N  
 Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Y N  
 Your current dental health is:    Good      Fair      Poor  
 Do you like your smile? Y N  
 Do your gums ever bleed? Y N  
 Have you ever had an injury to your: Mouth? Teeth? Chin?  
 Do you have any speech problems? Y N  
 If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Do you generally breathe through your mouth?    Awake? Y N  
Asleep? Y N  
 Do you have any missing, extra, or impacted permanent teeth? Y N