Meinhardt Orthodontics

Medical/Dental History for Adults

Date_____

Full Name_____ Nickname_____

Birthdate_____ Age_____ Sex_____ Home/Cell Phone_____

Street Address_____

City_____ State_____ Zip Code_____

I am: Single_____ Married _____ Widowed _____ Separated _____ Divorced _____

Emergency Contact _____ Phone_____

Other Family Members Treated _____

Occupation _____ Business Phone Number _____

Musical Instruments/Sports/Hobbies _____

Dental Insurance Coverage: yes _____ No _____ Please present dental insurance card(s) to the front desk

MEDICAL HISTORY

Physician _____

Do you feel as though you are in good health? Yes _____ No_____

If no, please explain: _____

Please check any of the following for which you have been diagnosed with or treated:

Diabetes ____	Asthma _____	Allergies _____	Rheumatic Fever _____
Heart Trouble ___	Epilepsy ____	Cancer ____	Bleeding disorders _____
Depression ____	Anemia _____	Seizures _____	ADD or ADHD _____
HIV/AIDS ____	Dizziness/Fainting _____	Migraines _____	Hip/Joint replacement _____

Please explain any checks above: _____

Have your tonsils and adenoids been removed? Yes _____ No _____ what age? _____

Are you currently or have you taken bisphosphonate drugs such as Zometa, Fosamax, Boniva, etc. for bone disorders or cancer? Yes _____ No _____ If yes, please explain:_____

Please list any drugs or medications you are taking _____

Latex Allergy? Yes _____ No_____

Do you take antibiotic pre-medication before any dental procedures? _____

Female Patients: Are you pregnant or anticipating becoming pregnant? _____

Any other medical issues not addressed above? _____

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 orthodontic treatment?

_____

_____

OVER ➡

DENTAL HISTORY

Dentist _____ Date of last Checkup/Cleaning _____

How often do you brush your teeth? _____ How often do you floss? _____

Have you ever been put on a tooth-brushing program or have a history of periodontal problems? Yes ____ No ___

If yes, please explain: _____

Have any teeth been injured due to accidents or falls? Yes _____ No ____ if yes, describe: _____

Have you had any severe head or face injures? Yes _____ No ____ if yes, describe: _____

Have you experienced any sensitivity or discomfort from: Gums_____ Teeth_____ Bite_____

Please explain: _____

Clench or grind teeth? Yes _____ No _____ Mouth breather? Yes _____ No _____

Previous Orthodontic work? Yes ____ No ____ if so, at what age (approx.)? _____

by whom? _____

Have you had any primary (baby) or permanent teeth removed? Yes _____ No _____

Clicking in jaw joints? Yes _____ No _____ Describe: _____

Pain in jaw joints? Yes _____ No _____ Describe: _____

Ever been treated for "TMJ" or "TMD" problems? Yes ____ No _____ Describe: _____

Any other dental issues not addressed above? _____

SMILE ANALYSIS

What is your primary concern? Why are you here? _____

_____

Do you feel the teeth are:

Crowded/overlapped? _____ Too far backward? _____

Spaced apart? _____ "Gummy" smile? _____

Too far forward? _____ Inadequate teeth shown when smiling? _____

Are there any other orthodontic issues not listed above that you wish to discuss? _____

_____

_____

I have read and understand the above questions. I will not hold my orthodontist or any member of his 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 Date

Medical changes/updates (please initial and date)

_____

_____