**PREMIER ORTHODONTICS**

**Medical Dental History Form for Adult Patients**

**PATIENT INFORMATION**

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

Patient: Mr. / Mrs. / Ms. / Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Circle One) (Last Name) (First Name) (Middle Initial)

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_ years \_\_\_\_\_\_\_\_\_ months \_\_\_\_\_\_\_\_\_\_\_

 Mo. Day Yr.

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Street) (City) (Zip)

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

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: ( ) Single ( ) Married ( ) Separated ( ) Divorced Social Security Number\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \*For insurance purposes

Is orthodontic insurance available? ( ) None ( ) Patient ( ) Spouse ( ) Other

Patient’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long: \_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I.D. Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_

(Please Give Your Dental Insurance Card to the Receptionist to Copy For Your File)

Patient’s Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ You were recommended to our office by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SPOUSE’S NAME**: Mr. / Mrs. / Ms. / Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long: \_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_I.D. Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_

 (Please Give Your Dental Insurance Card to the Receptionist to Copy For Your File)

## PERSON RESPONSIBLE FOR ACCOUNT

**Check one: ( ) Patient ( ) Spouse ( ) Both ( ) Guardian ( ) Parent**

## AUTHORIZATION

**I consent to the orthodontist’s use and disclosure of my records to carry out treatment, to obtain payment and for those activities and health care operations that are related to treatment or payment. I acknowledge that I have had an opportunity to review the office privacy notice and I am in agreement with the office privacy practices. I consent to the disclosure of my records, treatment information, appointments, etc. to the following persons who are involved in my care or payment for that care (i.e. spouse, parent, etc.). My consent to disclosure of records shall be effective until I revoke it in writing.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Print Name Relationship to Patient Print Name Relationship to Patient**

**I hereby authorize payment of the orthodontic insurance benefits to be made directly to Premier Orthodontics. I understand that I am responsible for all costs of diagnosis and treatment not paid by the insurance company. I hereby authorize the orthodontic office to administer and perform such diagnostic and treatment procedures as may be necessary for proper orthodontic care. The information on this page and the medical history are correct to the best of my knowledge. I will notify the orthodontist of any changes in my medical or dental health.**

## SIGNATURE OF PATIENT

X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH HISTORY and PATIENT INFORMATION**

*Your careful and completed answers to the following questions will be very helpful in the evaluation of your orthodontic problem*

**NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last medical examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_ Present Health? Good \_\_\_\_\_\_\_\_\_\_ Fair \_\_\_\_\_\_\_\_\_\_ Poor \_\_\_\_\_\_\_\_\_\_

Any history of a major illness? Yes \_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been under the care of a physician during the past two years other than for routine examination? Yes/ No

 ***Check any of the following for which the patient has been treated***:

Diabetes \_\_\_\_\_\_ Heart problems \_\_\_\_\_\_ Bone disorders \_\_\_\_\_\_ Hepatitis \_\_\_\_\_\_ Bleeding disorders \_\_\_\_\_\_ Joint pain \_\_\_\_\_\_

 Anemia \_\_\_\_\_\_ Ear infections \_\_\_\_\_\_ Headaches \_\_\_\_\_\_

 Cancer \_\_\_\_\_\_ Hormone disorders \_\_\_\_\_\_ Convulsions \_\_\_\_\_\_

 Aids / HIV \_\_\_\_\_\_ Stomach disorders \_\_\_\_\_\_ Tuberculosis \_\_\_\_\_\_ ­­Allergies \_\_\_\_\_\_ Asthma / Hay fever \_\_\_\_\_\_ Arthritis \_\_\_\_\_\_

If you answered yes to any of these questions, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you vomit, gag, or faint easily? Yes \_\_\_\_ No \_\_\_\_

Do you have a tendency for colds? \_\_\_\_ sore throats? \_\_\_\_ ear infections? \_\_\_\_ Yes \_\_\_\_ No \_\_\_\_

Have you had your tonsils and adenoids removed? What age? \_\_\_\_\_\_\_\_

List any allergies or drug sensitivity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Present drugs or medications being taken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have arthritis or pain in any joints of the body? Yes \_\_\_\_ No \_\_\_\_

Have you ever been treated for mental stress, nerves or any emotional problem? Yes \_\_\_\_ No \_\_\_\_

How many times a week do you have a headache? None \_\_\_\_ Few \_\_\_\_ Many \_\_\_\_

How many times a week do you take Aspirin, Tylenol or other pain medications? None \_\_\_\_ Few \_\_\_\_ Many \_\_\_\_

WOMEN: Are you pregnant at the present time? Yes \_\_\_\_ No \_\_\_\_\_

**DENTAL HISTORY**

Have you had any injury of any type to your face, teeth, chin, or jaws? Yes \_\_\_\_ No \_\_\_\_

 Give details of any injuries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been involved in any automobile, bike, swimming pool, or any other

sporting accident? Yes \_\_\_ No \_\_\_\_\_ Give details of any injuries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any pain in your jaw joints? Yes \_\_\_\_ No \_\_\_\_ Have you ever had any clicking or popping sounds from your jaw joints? Yes \_\_\_\_ No \_\_\_\_

Have you ever had a time when your jaw couldn’t open or close? Yes \_\_\_\_ No \_\_\_\_

Have you ever had any muscle pain, tiredness or stiffness of the jaw or neck? Yes \_\_\_\_ No \_\_\_\_

Do you grind or clench your teeth? While awake? \_\_\_\_\_ While asleep? \_\_\_\_\_ Yes \_\_\_\_ No \_\_\_\_

Have you experienced any problems with sore or bleeding gums? Yes \_\_\_\_ No \_\_\_\_

Do you have any speech problems? Yes \_\_\_\_ No \_\_\_\_

Do you play a musical instrument? Yes \_\_\_\_ No \_\_\_\_

Are there any parts of your mouth or any teeth that are sore to pressure or irritants?

 (cold, hot, sweets, biting hard foods etc. ) Yes \_\_\_\_ No \_\_\_\_

Have you ever had any unusual dental experiences? Yes \_\_\_\_ No \_\_\_\_

 Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any medical, dental or surgical problems not covered above? Yes \_\_\_\_ No \_\_\_\_

 Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***The following are some habits of interest to Dr. Quraishi. List information as it pertains to the patient*.**

Thumb sucking until age \_\_\_\_ years Tongue thrusting Yes \_\_\_\_ No \_\_\_\_

Finger sucking until age \_\_\_\_ years Mouth breathing Yes \_\_\_\_ No \_\_\_\_

Lip biting or lip sucking Yes \_\_\_\_ No \_\_\_\_ Nail biting Yes \_\_\_\_ N0 \_\_\_\_

Other habits Yes \_\_\_\_ No \_\_\_\_ Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***(PLEASE COMPLETE THE OTHER SIDE )***

**PATIENT’S ATTITUDE TOWARD TEETH, FACE AND ORTHODONTIC TREATMENT:**

**What are your main concerns regarding the jaws and teeth?**

Crowding \_\_\_ Deep bite \_\_\_ “Buck teeth” \_\_\_ Receding chin \_\_\_

Spaces \_\_\_ Open bite \_\_\_ “Under bite”\_ \_\_\_ Prominent chin \_\_\_

Overbite \_\_\_ Gum disease \_\_\_ Clicking jaw \_\_\_ Headaches \_\_\_

Jaw pain \_\_\_ Gummy smile \_\_\_ Missing teeth \_\_\_ Face proportions \_\_\_

Neck pain \_\_\_ Mouth too small \_\_\_ Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Orthodontic consultation prompted by:

 Dentist \_\_\_\_ Patient \_\_\_\_ Spouse \_\_\_\_ Father \_\_\_\_

 Physician \_\_\_\_ Friend \_\_\_\_ Sibling \_\_\_\_ Mother \_\_\_\_

 Other ( specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your interest in orthodontic treatment and braces:

 Want treatment \_\_\_ Treatment if necessary \_\_\_

 Unwilling but agree \_\_\_ Uncooperative \_\_\_

Do you brush your teeth:

 Several times a day \_\_\_ Nearly every day \_\_\_ Rarely \_\_\_

 Once a day \_\_\_ Occasionally \_\_\_ Never \_\_\_

Do you have dental check-ups:

 Twice a year \_\_\_ Once a year \_\_\_ Only if urgent \_\_\_ Never \_\_\_

Date of last dental check-up: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Next visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the dentist ever placed you on an oral hygiene program? Yes \_\_\_\_ No \_\_\_\_

Have you ever had any permanent teeth removed? Yes \_\_\_\_ No \_\_\_\_

Are there other family members with a similar orthodontic condition? Yes \_\_\_\_ No \_\_\_\_

 Mother \_\_\_\_ Father \_\_\_\_ Sister \_\_\_\_ Brother \_\_\_\_

Has anyone in the family had orthodontic treatment? Yes \_\_\_\_ No \_\_\_\_

 Mother \_\_\_\_ Father \_\_\_\_ Sister \_\_\_\_ Brother \_\_\_\_

Have you had a previous orthodontic consultation and / or treatment? Yes \_\_\_\_ No \_\_\_\_

 When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dr.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your favorite hobbies, sports, or pastimes? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By what name do you prefer to be called? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you aware that appointments will infringe on work time? Yes \_\_\_\_ No \_\_\_\_

Additional Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Thank you for your cooperation**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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