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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