Adult Health History Form
Patient Name:

Patient Information			
First Name:	Middle Initial:	Last Name:	
Nickname:	Birthdate:	Gender:	
Marital Status:	Spouse's Name:		
Address:	City:	State:	Zip:
Do you have Children? If so, Name and Ages:			
Person Financially Responsible:			
Home Phone:	Cell:	Work Phone:	
Which is the best number for contact?	Email (Used for Appointment Reminders):		
Hobbies:			
Whom can we thank for referring you?			

Insurance Information		
Dental Insurance Company:	Policy Number:	
Policy Holder's Name:	SSN:	Birthdate:
Policy Holder's Employer:	Work Phone:	
Secondary Dental Insurance:	Policy Number:	
Policy Holder's Name:	SSN:	Birthdate:
Policy Holder's Employer:	Work Phone:	

Dental History	
Dentist Name:	Date of Last Exam:
Does the patient currently have any untreated/unfinished dental needs?	
Has the patient had an orthodontic consult or treatment?	If so, when?
What is the patient's main orthodontic concern?	
Please select YES or No for the Following Questions and Explain as Necessary	
Speech problems/therapy?	Grind or clench teeth?
Oral habits (thumb/finger sucking, lip/nail biting)?	Injury to face, jaw, teeth or mouth?
Pain, tenderness or noise in jaw?	Unbalanced Jaw Size/Growth
Apprehensive about dental care?	Brush Teeth Twice Daily?
Floss teeth daily?	Mouth breathing?
Snores during sleep?	Requires premedication?
Any Missing or Extra Permanent Teeth?	Family History With Orthodontics

Medical History		
Physician Name:	Date of Last Exam:	
Address:	City:	Zip:
List any medications currently being taken by the patient:		
List any drug allergies or sensitivities that the patient may have:		

Please select YES or No for the following questions and explain as necessary.

Rheumatic Fever	Tuberculosis/ Lung Disease	Pneumonia
Liver Disease	Kidney Disease	Heart Attack/Stroke
Heart Disease	Congenital Heart Defect	Heart Murmur
Hemophilia	Hypertension/High Blood Pressure	Prolonged Bleeding/Transfusion
Anemia	HIV/AIDS	Hepatitis
Tonsils/Adenoids Removed	Cancer	Received Radiation Treatment
Growth Problems	Endocrine Problems	Hormone Therapy
If Female, Pregnant or Nursing	Latex/Metal Allergy	Nervous Disorders
Bone Disorders/Bone Loss	Diabetes	Seizures/Epilepsy
Handicaps/Disabilities	Asthma	Arthritis
Treated for Emotional Problems	Osteoporosis or Low Bone Density	Autism
ADHD/ADD		
Please explain any 'Yes' responses from above:		

Responsible Party Name:	Date: