Zweihorn ORTHODONTICS

Member American Association of Orthodontists
My Life. My Smile. My Orthodontist.®

MEDICAL/DENTAL HISTORY FORM FOR ADULTS (OVER 18 YEARS OF AGE)

CONFIDENTIAL Date: _____

Please Complete All Fields. If Not Applicable, Please Write N/A

Title: _____ Last Name: _____ First Name: _____ Middle Name/Initial: ____

Prefers To Be Called: _____

Birth Date: _____ Age: ____ Sex: Male ◯ Female ◯

Home Phone No:_____ Cell Phone No: _____

Patient's Address: _____

City: _____ State: _____ Zip Code: _____

Other Family Members Treated Here: _____

Name Of Patient's Dentist: _____ Phone No: _____

Date Last Seen:_____ Reason: _____

Who Is Financially Responsible For This Account?

Last Name: _____ First Name: _____ Middle Name/Initial: ___

Address: _____ Occupation: _____ Employer: _____

Years at current work: ___ Home Phone No:_____Work Phone:_____

Insurance Coverage For Dental Treatment? Yes ◯ No ◯

Insurance Coverage For Orthodontic Treatment? Yes ◯ No ◯

Who suggested that you might need orthodontic treatment? _____

How did you select our office?

☐ Dentist Referred _____ ☐ Friend Referred _____

☐ Other _____ ☐ Saw the Sign _____

I certify that the above information is true and accurate to my knowledge:_____

Authorization of Benefits

I hereby authorize direct payment of the dental benefits otherwise payable to me, directly to Zweihorn Orthodontics

_____	_____	_____	_____
Signature – Subscriber	Date	Office Staff	Date

Please also complete the health history on the next page.

A thorough health history is essential to a complete orthodontic evaluation. Your answers are for office records only, and are confidential. For the following questions, please mark *yes, no*, **or** *don't know/don't understand (dk/u).*

MEDICAL HISTORY

Now or in the past, have you any:

Yes no dk/u Birth defects or hereditary problems?
Yes no dk/u Bone fractures, or any injuries to face, head, neck?
Yes no dk/u Arthritis or joint problems?
Yes no dk/u Cancer, tumor, radiation treatment or chemotherapy?
Yes no dk/u Endocrine or thyroid problems?
Yes no dk/u Diabetes or low blood sugar?
Yes no dk/u Kidney problems?
Yes no dk/u Immune system problems?
Yes no dk/u History of osteoporosis?
Yes no dk/u Sexually transmitted disease?
Yes no dk/u AIDS or HIV positive?
Yes no dk/u Hepatitis, jaundice or other liver problems?
Yes no dk/u Polio, mononucleosis, tuberculosis, pneumonia?
Yes no dk/u Seizures, fainting spells, neurologic problem?
Yes no dk/u Mental health disturbance or depression?
Yes no dk/u History of eating disorder (anorexia, bulimia)?
Yes no dk/u Frequent headaches or migraines?
Yes no dk/u High or low blood pressure?
Yes no dk/u Excessive bleeding or bruising tendency, anemia?
Yes no dk/u Chest pain, shortness of breath, swollen ankles?
Yes no dk/u Heart defects, heart murmur, rheumatic heart disease?
Yes no dk/u Angina, arteriosclerosis, stroke or heart attack?
Yes no dk/u Skin disorder (other than common acne)?
Yes no dk/u Do you eat a well-balanced diet?
Yes no dk/u Vision, hearing, or speech problems?
Yes no dk/u Frequent ear infections, colds, throat infections?
Yes no dk/u Asthma, sinus problems, hayfever?
Yes no dk/u Tonsil or adenoid condition?
Yes no dk/u Have you ever taken bisphosphonates for bone disorders or cancer?

Have you had allergies or reactions to any of the following?

Yes no dk/u Local anesthetics (novocaine, lidocaine, xylocaine)
Yes no dk/u Latex (gloves, balloons)
Yes no dk/u Aspirin
Yes no dk/u Ibuprofen (Motrin, Advil)
Yes no dk/u Penicillin
Yes no dk/u Other antibiotics:
Yes no dk/u Metals (jewelry, clothing snaps)
Yes no dk/u Foods:
Yes no dk/u Other substances:

DENTAL HISTORY

Now or in the past, have you any:

Yes no dk/u Supernumerary (extra) teeth or missing teeth?
Yes no dk/u Chipped or injured teeth?
Yes no dk/u Sensitive or sore teeth?
Yes no dk/u Jaw fractures, cysts, infections?
Yes no dk/u Teeth treated with root canals or pulpotomies?
Yes no dk/u "Gum boils," frequent canker sores or cold sores?
Yes no dk/u History of speech problems or speech therapy?
Yes no dk/u Difficulty breathing through the nose? Snoring?
Yes no dk/u Frequent oral habits (sucking finger, chewing pen, etc.)?
Yes no dk/u Teeth causing irritation to lip, cheek or gums?
Yes no dk/u Tooth grinding or jaw clenching?
Yes no dk/u Clicking, locking, or pain in jaw joints or muscles?
Yes no dk/u History of "TMJ Problems?"
Yes no dk/u Broken or missing fillings?
Yes no dk/u Trouble with previous dental treatment?
Yes no dk/u History of gum disease?
Yes no dk/u Orthodontic consultation or treatment before now?

How often do you brush?
How often do you floss?

PATIENT HEALTH INFORMATION

List all medications, nutritional supplements, herbal medications and non-prescription medicines, including fluoride supplements that you take:

Antibiotic pre-medication before any dental treatment? Yes No
Have you any history of substance abuse or a current issue?
Do you chew or smoke tobacco?
Have you noticed any changes in your face or jaws?
Any other physical problems?

Women: Are you pregnant? Yes No
Are you trying to become pregnant? Yes No

FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following health problems?

Bleeding disorders
Diabetes
Arthritis
Severe allergies
Unusual dental problems
Jaw size imbalance
Other family medical conditions

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature:

Date:

I have read the above questions and understand them. I will not hold the doctor or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I will notify the doctor of any changes in my medical or dental health.

Signature:

Date: