

ADULT MEDICAL HISTORY FORM

Date: _____

Patient's Name _____ Date of Birth: _____

Address: _____ Age: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail address: _____ SS#: _____

Spouse's Name: _____ Referred to Dr. Hutta by: _____

Person responsible for financial obligations: _____

SS#: _____ Date of Birth: _____

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Is Orthodontic Treatment covered by your insurance? Y / N

Name of Insurance Company: _____

PATIENT'S DENTIST: _____ PATIENT'S PHYSICIAN: _____

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Date of last dental check-up: _____ Any Facial/Dental Injuries: Y / N

Please describe: _____

Any baby or permanent teeth removed by your dentist: _____

Thumb or finger sucking habit? Yes / No Until age: _____

Any difficulty breathing through nose (awake/sleep): _____

Any tooth clenching/grinding? Yes / No

Any clicking or pain when opening/closing the mouth? Yes / No

Any speech problems? _____

MEDICAL HISTORY

Are you currently under the care of a physician? Yes / No If so, why: _____

Are you taking any medication now? Yes / No Is so, what kind: _____

Any allergies or drug sensitivity? Yes / No If so, what: _____

Have tonsils/adenoids been removed? Yes / No At what age: _____

Please describe any present or past medical problems: _____

Hospitalizations and operations: _____

Is pre-medication needed with antibiotic before dental visits? Yes / No *(Please turn over)*

Have you ever had any of the following diseases/disorders? Please circle all that apply.

stays in hospitals	artificial bones/joints	psychiatric problems
cancer/chemotherapy	high/low blood pressure	diabetes/T.B.
heart murmur	sinus problems	epilepsy/seizures
hearing impairment	fever blisters	hemophilia
any operations	severe/frequent headaches	asthma
difficulty breathing	hospitalized for any reason	hepatitis
blood transfusion	hyperactive	other: _____

Please describe any other problems not listed: _____

What concerns you most about your teeth and facial appearance? _____

Have other members of your family been seen in our office? Yes/No If so, who: _____

Does anyone in your family have a similar dental problem? Yes/No If so, who: _____

Number of brothers: _____ Ages: _____

Number of sisters: _____ Ages: _____

I understand that the information I have given here today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical history. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment. Records can be released for a fee of \$200.00. I understand that where appropriate credit reports may be obtained.

(please sign name)

(today's date)

FOR OFFICE USE ONLY

Class:	I	II, div. 1	II, div. 2	II subdiv	III
Dentition:	deciduous	mixed	permanent		
Arch length discrepancies:	none		moderate	severe	
Crossbite:			Overbite:		Overjet:
Habits/Special Functions:					Hygiene:
TMJ:	normal	crepitus	pain		left-right
Dental/Skeletal midlines:					
Told:	M	F	PT		

Full Tx	Partial Tx	Pre-Ortho Guidance
Extraction	Guidance	Pre-Ortho Guidance

Type of Tx: Extraction Non-extraction

Has patient been to another orthodontist: _____

Status after I.E.: _____ Estimated Tx time: _____ Estimated Tx fee: _____