



Adult History Form

Date _____

Patient name _____
Sex _____ Age _____ Birth date _____ Home phone # _____
Address _____
Cell phone # _____ Work phone # _____
Email _____ Best number to be contacted at _____
Occupation _____ Employer _____
Orthodontic insurance _____ Birth date _____ SS# _____

Spouse's name _____ Cell phone # _____
Occupation _____ Employer _____
Work phone # _____ Best number to be contacted at _____
Orthodontic insurance _____ Birth date _____ SS# _____

Other financially responsible party _____ Relationship _____
Address _____
Home phone number _____ Best number to be contacted at _____
Occupation _____ Employer _____
Orthodontic insurance _____ Birth date _____ SS# _____

Who referred you to our office? _____
Family members we have seen _____
Dentist _____ Date of last cleaning _____
Date of last panoramic x-ray _____ Any previous ortho treatment? Y or N
Previous orthodontist _____ Date of treatment _____

Medical History

Please circle if the patient has or had any of the following:

- | | | |
|---------------------|--------------------------|---------------------|
| Heart disease | Epilepsy | Gum disease |
| Kidney disease | AIDS/HIV+ | Current thumb habit |
| High blood pressure | Clicking jaw joints | Past thumb habit |
| Hepatitis | Frequent headaches | Speech problems |
| Rheumatic fever | Difficulty chewing | Breathing problems |
| Heart murmur | Grinding/clenching teeth | Tonsillectomy |
| Diabetes | Morning jaw stiffness | Allergies _____ |
| Stroke | Pain in jaw joints | |

Please list any other relevant medical conditions:

Please list all medications patient is taking:

I the undersigned have given the above information and certify that it is accurate.

Signature _____ Date _____