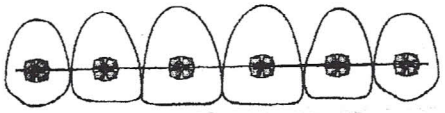
CONFIDENTIAL



LINDENHURST ORTHODONTICS

MEDICAL DENTAL HISTORY FORM - ADULT

DATE: _____

Patient's Last Name: _____ First Name: _____ Middle Name/Initial: _____

Birth Date: _____ Age: _____ Sex: ❒ Male ❒ Female

Home Phone No.: _____ I prefer to be called (nickname): _____

S.S.N./S.I.N.: _____ E-mail address: _____ Cell Phone No.: _____

Patient's Address: _____

City: _____ State: _____ Zip: _____

Referred by? _____

Patient is: ❒ Single: ❒ Married: ❒ Widowed: ❒ Separated: ❒ Divorced:

Employer: _____

Occupation: _____ Business Phone : _____

Name of spouse / closest relative _____ Phone No. (if different from yours): _____

Relationship: _____

Address: (if different than patient's): _____

City: _____ State: _____ Zip: _____

Name of Patient's Dentist: _____ Phone No.: _____

Dentist's Address: _____

City: _____ State _____ Zip: _____

Date last seen: _____

Name of Patient's Physician: _____ Phone No.: _____

Physician's Address: _____

City: _____ State: _____ Zip: _____

Date last seen: _____

Who is financially responsible for this account? _____

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

Address (if different from patient's): _____

City: _____ State: _____ Zip: _____

Phone No.: (if different than patient's) _____ S.S.N. / S.I.N.: _____

Insurance Coverage for Orthodontic Treatment?: ❒ Yes ❒ No

Primary Policy Holder's Name: _____ S.S.N. / S.I.N.: _____

Birth Date: _____ Employed By: _____

Dental Insurance Company: _____ Group No.: _____

Secondary Policy Holder's Name: _____ S.S.N. / S.I.N.: _____

Birth Date: _____ Employed By: _____

Dental Insurance Company: _____ Group No.: _____

SEE SECOND SIDE

MEDICAL HISTORY

Now or in the past, have you had:

- ❒ YES ❒ NO Birth defects, or hereditary problems?
- ❒ YES ❒ NO Bone fractures, any major accidents?
- ❒ YES ❒ NO Rheumatoid or arthritic conditions?
- ❒ YES ❒ NO Endocrine or thyroid problems?
- ❒ YES ❒ NO Kidney problems?
- ❒ YES ❒ NO Diabetes?
- ❒ YES ❒ NO Cancer, tumor, radiation treatment or chemotherapy?
- ❒ YES ❒ NO Stomach ulcer or hyperactivity?
- ❒ YES ❒ NO Polio, mononucleosis, tuberculosis, pneumonia?
- ❒ YES ❒ NO Problems of the immune system?
- ❒ YES ❒ NO AIDS or HIV positive?
- ❒ YES ❒ NO Hepatitis, jaundice or liver problem?
- ❒ YES ❒ NO Fainting spells, seizures, epilepsy or neurological problems?
- ❒ YES ❒ NO Mental health disturbance or depression?
- ❒ YES ❒ NO Vision, hearing, tasting or speech difficulties?
- ❒ YES ❒ NO Loss of weight recently, poor appetite?
- ❒ YES ❒ NO History of eating disorder (anorexia, bulimia)?
- ❒ YES ❒ NO Excessive bleeding or bruising tendency, anemia or bleeding disorder?
- ❒ YES ❒ NO High or low blood pressure?
- ❒ YES ❒ NO Tired easily?
- ❒ YES ❒ NO Chest pain, shortness of breath or swelling ankles?
- ❒ YES ❒ NO Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
- ❒ YES ❒ NO Skin disorder?
- ❒ YES ❒ NO Does the patient eat a well-balanced diet?
- ❒ YES ❒ NO Frequent headaches, colds or sore throats?
- ❒ YES ❒ NO Eye, ear, nose or throat condition?
- ❒ YES ❒ NO Hayfever, asthma, sinus trouble or hives?
- ❒ YES ❒ NO Tonsil or adenoid conditions?
- ❒ YES ❒ NO Osteoporosis?

ALLERGIES OR REACTIONS TO ANY OF THE FOLLOWING:

- ❒ YES ❒ NO Local anesthetics (Novocaine or Lidocaine)
- ❒ YES ❒ NO Aspirin
- ❒ YES ❒ NO Ibuprofen (Motrin, Advil)
- ❒ YES ❒ NO Penicillin or other antibiotics
- ❒ YES ❒ NO Sulfur drugs
- ❒ YES ❒ NO Codeine or other narcotics
- ❒ YES ❒ NO Metals (jewelry, clothing snaps)
- ❒ YES ❒ NO Latex (gloves, balloons)
- ❒ YES ❒ NO Vinyl
- ❒ YES ❒ NO Acrylic
- ❒ YES ❒ NO Animals
- ❒ YES ❒ NO Foods (specify) _____
- ❒ YES ❒ NO Other substances (specify) _____
- ❒ YES ❒ NO Is the patient taking medication? Please name them.

Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____

Do you have any other medical conditions that we should know about?

_____

WOMEN ONLY

- ❒ YES ❒ NO Are you pregnant?
- ❒ YES ❒ NO Are you anticipating becoming pregnant?

DENTAL HISTORY

Now or in the past, has the patient had:

- ❒ YES ❒ NO Teeth sensitive to hot or cold, teeth throb or ache?
- ❒ YES ❒ NO Bleeding gums, bad taste or mouth odor?
- ❒ YES ❒ NO Periodontal "gum problems"?
- ❒ YES ❒ NO Abnormal swallowing habit (tongue thrusting)?
- ❒ YES ❒ NO History of speech problems?
- ❒ YES ❒ NO Mouth breathing habit, snoring or difficulty in breathing?
- ❒ YES ❒ NO Tooth grinding or jaw clenching?
- ❒ YES ❒ NO Any pain, clicking or locking in jaw or ringing in the ears?
- ❒ YES ❒ NO Any pain or soreness in the muscles of the face or around the ears?
- ❒ YES ❒ NO Difficulty in chewing or jaw opening?
- ❒ YES ❒ NO Have you ever been treated for "TMD" or "TMJ" problems?
- ❒ YES ❒ NO Concerned about spaced, crooked or protruding teeth?
- ❒ YES ❒ NO Aware or concerned about under or over developed jaw?
- ❒ YES ❒ NO Any wisdom tooth problems?
- ❒ YES ❒ NO Had periodontal (gum) treatment?
- ❒ YES ❒ NO Any serious trouble associated with any previous dental treatment?
- ❒ YES ❒ NO Ever had a prior orthodontic examination or treatment?

How often do you brush? _____ Floss? _____

What is your primary concern? _____

Why are you here? _____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: _____ Date Signed: _____
(Patient)

Signed: _____ Date Signed: _____
(Dental staff member)

MEDICAL HISTORY UPDATE OR CHANGES: _____

_____

_____

Signed: _____ Date Signed: _____
(Patient)

Signed: _____ Date Signed: _____
(Dental staff member)