VYAS ORTHODONTICS

Medical Dental History Form
For Adult Patients

PATIENT

Date _____

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

Title Mr. Mrs. Ms. Miss Dr. Other Date of Birth _____ Age _____ Sex: Male Female

Home Address _____ City, State, Zip code _____

Marital Status: Single Married Partner Separated Divorced Widowed

Cell phone ( ) _____ - _____ Home phone ( ) _____ - _____ Work phone ( ) _____ - _____

Social security # _____ Employer _____ Occupation _____

EMAIL ADDRESS _____

CLOSEST RELATIVE

Spouse or closest relatives name _____ Relationship to the patient _____

Address (if different than patient address) _____

Cell phone ( ) _____ - _____ Home phone ( ) _____ - _____ Work phone ( ) _____ - _____

Employer _____ Occupation _____

Patient's Dentist _____ Address, City, State _____

Patient's Physician _____ Address, City, State _____

DENTAL INSURANCE

Primary policy holder's full name _____ Date of Birth _____

Social security # _____ Relationship to patient _____

Insurance Company _____ Address _____

Group # _____ ID# _____ Employer _____

Secondary policy holder's full name _____ Date of Birth _____

Social security # _____ Relationship to patient _____

Insurance Company _____ Address _____

Group # _____ ID# _____ Employer _____

GENERAL INFORMATION

What concerns you about your teeth? _____

Who referred you to our office? _____

Have any other family members been treated in our office? Please name them. _____

_____

Have you ever had orthodontic treatment? _____

MEDICAL HEALTH INFORMATION

List any medication, nutritional supplements, herbal medications or non-prescription medicines that you take.

_____

Are you allergic to any food, medicine, other? What? _____

Women: Are you pregnant? Yes No

Has any member of the family had a problem with general anesthetic? Yes No

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation.

For the following questions, please mark yes, no, or don't know/understand (dk/u).

MEDICAL HISTORY

Now or in the past, have you had:

Yes	No	DK/U	
☐	☐	☐	AIDS or HIV positive?
☐	☐	☐	Birth defects or hereditary problems?
☐	☐	☐	Bone fractures or major injuries?
☐	☐	☐	Any injuries to face, head, neck?
☐	☐	☐	Arthritis or joint problems?
☐	☐	☐	Endocrine or thyroid problems?
☐	☐	☐	Diabetes or low sugar?
☐	☐	☐	Kidney problems?
☐	☐	☐	Seizures, fainting spells, neurologic problems?
☐	☐	☐	Cancer, tumor, radiation treatment?
☐	☐	☐	Chemotherapy?
☐	☐	☐	Vision, hearing, or speech problems?
☐	☐	☐	Stomach ulcer, hyperacidity, acid reflux?
☐	☐	☐	Immune system problems?
☐	☐	☐	History of eating disorder (anorexia, bulimia)?
☐	☐	☐	History of osteoporosis?
☐	☐	☐	High or low blood pressure?
☐	☐	☐	Excessive bleeding or bruising, anemia?
☐	☐	☐	Heart defects, heart murmur?
☐	☐	☐	Frequent headaches or migraines?
☐	☐	☐	Frequent ear infections, colds, throat infections?
☐	☐	☐	Asthma, sinus problems, hay fever?
☐	☐	☐	Hepatitis, jaundice, or other liver
☐	☐	☐	Tonsils or adenoids removed?

DENTAL HISTORY

Now or in the past, have you had:

Yes	No	DK/U	
☐	☐	☐	Permanent or extra teeth removed?
☐	☐	☐	Extra or congenitally missing teeth?
☐	☐	☐	Chipped or injured teeth?
☐	☐	☐	Any sensitive or sore teeth?
☐	☐	☐	Bleeding gums, bad taste or odor?
☐	☐	☐	Jaw fractures, cysts, infections?
☐	☐	☐	Snoring at night?
☐	☐	☐	Thumb/finger sucking?
☐	☐	☐	Tongue thrust?
☐	☐	☐	Tooth grinding or clenching?
☐	☐	☐	Clicking, locking in jaw joints?
☐	☐	☐	Soreness in jaw or face muscles?
☐	☐	☐	Ringing in ears?
☐	☐	☐	Difficulty in chewing?
☐	☐	☐	Difficulty in opening jaw?
☐	☐	☐	Treated for "TMJ" or "TMD"?
☐	☐	☐	Do you frequently breathe through your mouth?
☐	☐	☐	Any serious trouble associated with previous dental treatment?

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 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. I will notify my orthodontist of any changes in my medical or dental health. I give the doctor permission to use such measures as deemed necessary in her professional judgment to render a diagnosis. This would include an oral examination, radiographs, and other diagnostic aids. I have received a copy of this office's Notice of Privacy Practices.

Signature: _____ **Date:** _____