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This form is confidential

Medical-Dental History Form for Adults

Last Name____________________________________ First name__________________________ M.I.______

Birth date_____________ Age______ Gender______ I preferred to be called_____________________________

Home street address____

City____ State__________ Zip________________

Home phone ( ) _________-__________________ Cell phone ( ) _________-___________________

E-Mail address____

Who referred you to our practice?____

Occupation_______________________________Employer____________________________________Years_____

Business address______________________________________City_________________State_____Zip__________

Business phone ( )_________-____________________________Extension___________

Who to contact in an emergency____

Relationship_______________________Phone ( ) _________-____________________

Address (if different than yours)____

City____State__________Zip________________

Name of your general dentist____

City your dentist is located_______________________________Phone ( )_________-__________________

Name of your family physician____

City your physician is located____________________________Phone ( )_________-__________________

Person responsible for your account (if not yourself)____

Address____City____________________State_____Zip__________

Phone ( )________-___________________

Dental insurance information (primary): Policy holder's employer____

Insurance Co.____ Group #__________________________

Policy holder's S.S.#_________-_______-___________ Policy holder's date of birth______/______/______

Dental insurance information (secondary): Policy holder's employer____

Insurance Co.____ Group #__________________________

Policy holder's S.S.#_________-_______-___________ Policy holder's date of birth______/______/______

Medical History

Now or in the past, have you had any of the following?

Birth defects or hereditary conditions	___yes ___no	Major accidents	___yes ___no
Rheumatoid or arthritic conditions	___yes ___no	Osteoporosis	___yes ___no
Endocrine or thyroid conditions	___yes ___no	Kidney problems	___yes ___no
Cancer, tumors, radiation or chemotherapy	___yes ___no	Diabetes	___yes ___no
Polio	___yes ___no	Mononucleosis	___yes ___no
Tuberculosis	___yes ___no	Pneumonia	___yes ___no
Tonsil or adenoid condition	___yes ___no	Stomach ulcers	___yes ___no
Hepatitis, jaundice or liver conditions	___yes ___no	AIDS or HIV+	___yes ___no
Mental health problems or depression	___yes ___no	Fainting, seizures, epilepsy	___yes ___no
Vision, hearing, tasting or speech problems	___yes ___no	Recent loss of weight	___yes ___no
Eating disorders (anorexia or bulimia)	___yes ___no	Bleeding or blood disorders	___yes ___no
High___ or low___ blood pressure	___yes ___no	Chest pain	___yes ___no
Cardiovascular problems	___yes ___no	Shortness of breath	___yes ___no
Heart murmur or congenital heart defects	___yes ___no	Skin disorders	___yes ___no
Hay fever, chronic allergies, asthma	___yes ___no	Frequent headaches	___yes ___no
Substance abuse problem	___yes ___no	Chew or smoke tobacco	___yes ___no

Please describe any other medical condition that we should know about:

Do you have an allergy or reaction to any of the following?

___Local anesthetics (Novocaine, Lidocaine)	___Ibuprofen (Motrin, Advil)	___Aspirin
___Acetominophen (Tylenol)	___Penicillin or other antibiotics	___Sulfa drugs
___Codeine or other narcotics	___Metals	___Latex
___Vinyl	___Acrylic	___Foods____________________

Do you require antibiotic medication prior to your dental cleaning appointments? ___yes ___no

Please list any medications that your are currently taking: **Taken for:**

Women

Are you pregnant? ___yes ___no Do you take birth control pills? ___yes ___no

Do you take medication for Osteoporosis (ex. Fosamax, Boniva) ___yes ___no

Family Medical History

Do your parents or siblings have or ever had any of the following conditions?

Diabetes____________________________ Arthritis_____________________________ Bleeding disorders____________________

Extra teeth or undeveloped teeth_____________________________ Long lower jaw or "underbite")___________________________

Dental History

Do you have or ever had any of the following?

Extra or undeveloped teeth	___yes	___no	Permanent or extra teeth removed	___yes	___no
Teeth sensitive to hot or cold	___yes	___no	Jaw fracture or jaw cyst	___yes	___no
Periodontal "gum" problems	___yes	___no	Thumbsucking habits	___yes	___no
Speech problems	___yes	___no	Mouth breathing or snoring	___yes	___no
Teeth grinding or clenching	___yes	___no	Pain or locking of the jaw	___yes	___no
Pain or soreness of the jaw muscles	___yes	___no	Difficult jaw opening	___yes	___no
Frequent cheek or lip biting	___yes	___no	Frequent cold or canker sores	___yes	___no

Have you ever had an injury to a tooth or broken a tooth? ___yes ___no

Explain____

Have you ever had any of the following dental treatment?

Wisdom tooth removal	___yes	___no	Periodontal "gum" treatment	___yes	___no
TMJ jaw joint treatment	___yes	___no	Orthodontic treatment	___yes	___no

Are you aware of any dental procedures that are planned by your general dentist (ex. cavities, fillings, crowns, extractions, root canals, implants)?____

List any other dental specialist who is providing care for you____

Why are you here for an orthodontic examination?____

Do you feel that your front teeth are:

___Too small or short ___Too large or long ___Crooked or crowded ___Not centered

___Misshaped, uneven or worn ___Spaced apart ___Protruded ("sticking out") ___Biting in an "underbite"

Do you feel that you show too much gum tissue when smiling? ___yes ___no

I would like to show ____more or ____less teeth when I smile.

If your facial appearance could be changed, what would you change?_____________________________________

___Move my chin forward ___Move my chin back ___Center my chin

___Move my lips outward ___Move my lips inward or have them close easier

If you had to wear orthodontic braces, would you accept that they were visible?

___Yes, I am okay with it ___Probably, if that were the only way to get a good result ___No, absolutely not

I have read and understand the above questions. I will not hold Dr. Miyawaki or any member of his 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.

Your signature____ Date_____________________