ADULTS

LINEBERGER ORTHODONTICS

WELCOME TO OUR OFFICE

MEDICAL DENTAL HISTORY FORM

Date: _____ Patient's Name: _____
LAST FIRST MIDDLE

Mailing Address: _____
STREET CITY STATE ZIP

Home phone: _____ Cell phone: _____ Birth Date: _____

Social Security #: _____ Patient Email: _____

Method of appointment reminder: ☐ Email ☐ Text _____

Referred By: _____ General Dentist's Name: _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Marital Status: _____
LAST FIRST MIDDLE

Billing Address: _____
STREET CITY STATE ZIP

Home Phone: _____ Cell Phone: _____

Social Security #: _____ Birth Date: _____ Relationship to Patient: _____

Responsible Party Email: _____

Spouse's Name: _____
LAST FIRST MIDDLE

INSURANCE INFORMATION

Policy Holder: _____ DOB: _____ Policy Holder SSN: _____

Insurance Company: _____ ID #: _____

Insurance Co. Address: _____

Do you have dual coverage? ☐ Yes ☐ No If Yes, please continue:

Policy Holder Name: _____ DOB: _____ Policy Holder SSN: _____

Insurance Company: _____ ID #: _____

Insurance Co. Address: _____

EMERGENCY INFORMATION

Name: _____

Phone: _____ Relationship to Patient _____

CHILD

LINEBERGER ORTHODONTICS

WELCOME TO OUR OFFICE

MEDICAL DENTAL HISTORY FORM

Date: _____ School: _____

Patient's Name: _____
LAST FIRST MIDDLE

Mailing Address: _____
STREET CITY STATE ZIP

Home Phone: _____ Cell Phone: _____ Birth Date: _____

Method of appointment reminder: ☐ Email ☐ Text _____

Referred By: _____ General Dentist's Name: _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Marital Status: _____
LAST FIRST MIDDLE

Billing Address: _____
STREET CITY STATE ZIP

Home Phone: _____ Cell Phone: _____

Social Security #: _____ Birth Date: _____ Relationship to Patient: _____

Responsible Party Email: _____

Employer: _____

INSURANCE INFORMATION

Policy Holder: _____ DOB: _____ Policy Holder SSN: _____

Insurance Company: _____ ID #: _____

Insurance Co. Address: _____

Do you have dual coverage? ☐ Yes ☐ No If Yes, please continue:

Policy Holder Name: _____ DOB: _____ Policy Holder SSN: _____

Insurance Company: _____ ID #: _____

Insurance Co. Address: _____

EMERGENCY INFORMATION

Name: _____

Phone: _____ Relationship to Patient _____

For the following questions mark yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Now or in the past, have you had:

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

Allergies or reactions to any of the following:

☐ yes ☐ no ☐ dk/u Latex (gloves, balloons)
☐ yes ☐ no ☐ dk/u Metals (jewelry, clothing, snaps)
☐ yes ☐ no ☐ dk/u Local anesthetics, such as lidocaine
☐ yes ☐ no ☐ dk/u Acrylic
☐ yes ☐ no ☐ dk/u Medications (please specify) _____
☐ yes ☐ no ☐ dk/u Foods (please specify)_____
☐ yes ☐ no ☐ dk/u Other (please specify)_____
☐ yes ☐ no ☐ dk/u Are you taking medication, nutrient supplements, herbal medications, or non-prescription medicing? If yes, please name them:

Medication _____ Taken for _____

☐ yes ☐ no ☐ dk/u Do you currently have or ever had a substance abuse problem?
☐ yes ☐ no ☐ dk/u Do you smoke or chew tobacco?
☐ yes ☐ no ☐ dk/u Operations? Describe: _____
☐ yes ☐ no ☐ dk/u Hospitalized? For: _____
☐ yes ☐ no ☐ dk/u Being treated by another healthcare professional?

If yes, for: _____

☐ yes ☐ no ☐ dk/u Other physical problems or sympstoms?

Describe: _____

Are there any other medical conditions (including family medical conditions) that we should be aware of? _____

Now or in the past, have you had:

☐ yes ☐ no ☐ dk/u Permanent or "extra" (supernumerary) teeth removed?
☐ yes ☐ no ☐ dk/u Supernumerary (extra) or cengenitally missing teeth?
☐ yes ☐ no ☐ dk/u Chipped or otherwise injured promary (baby) or permanent teeth?
☐ yes ☐ no ☐ dk/u Teeth sensitive to hot or cold; teeth throb or ache?
☐ yes ☐ no ☐ dk/u "Dead Teeth" or root canals treated?
☐ yes ☐ no ☐ dk/u Bleeding gums, bad taste or mouth odor?
☐ yes ☐ no ☐ dk/u Periodontal "gum problems"?
☐ yes ☐ no ☐ dk/u Food impaction between teeth?
☐ yes ☐ no ☐ dk/u "Gum Boils", frequent canker sores or cold sores?
☐ yes ☐ no ☐ dk/u Thumb, finger, or sucking habit? Until what age? ____
☐ yes ☐ no ☐ dk/u Abnormal swallowing habit (tongue thrusting)?
☐ yes ☐ no ☐ dk/u History of speech problems?
☐ yes ☐ no ☐ dk/u Mouth breathing habit, snoring or difficulty breathing?
☐ yes ☐ no ☐ dk/u Tooth grinding, jaw clenching clicking or locking?
☐ yes ☐ no ☐ dk/u Any pain in jaw or ringing in the ears?
☐ yes ☐ no ☐ dk/u Any pain or soreness in the muscles of the face or around the ears?
☐ yes ☐ no ☐ dk/u Difficulty encountered in chewing or jaw opening?
☐ yes ☐ no ☐ dk/u Have you ever been treated for TMD or TMJ problems?
☐ yes ☐ no ☐ dk/u Aware of loose, broken or missing restorations (fillings)?
☐ yes ☐ no ☐ dk/u Any teeth irritating cheeck, lip, tongue or palate?
☐ yes ☐ no ☐ dk/u Concerned about spaced, crooked, or protruding teeth?
☐ yes ☐ no ☐ dk/u Aware or concerned about under or over developed jaw
☐ yes ☐ no ☐ dk/u Any relative with similar tooth or jaw relationships?
☐ yes ☐ no ☐ dk/u Any wisdom tooth problems?
☐ yes ☐ no ☐ dk/u Had periodontal (gum) treatment ?
☐ yes ☐ no ☐ dk/u Had any serious trouble associated with any previous dental treatment?
☐ yes ☐ no ☐ dk/u Been under another dentist's care?
☐ yes ☐ no ☐ dk/u Been under another dental specialists care?
☐ yes ☐ no ☐ dk/u Ever had a prior orthodontic examination or treatment?
☐ yes ☐ no ☐ dk/u Would you object to wearing orthodontic appliances (braces) should they be indicated?

Women Only:

☐ yes ☐ no ☐ dk/u Are you pregnant?
☐ yes ☐ no ☐ dk/u Are you anticipating becoming pregnant?