JohnMartin DMD, MS
ORTHODONTIST
Braces • TMJ • Headache Relief

ADULTS

WELCOME TO OUR OFFICE

MEDICAL DENTAL HISTORY FORM
ADULT FORM

Date: ______________________

Patient's Name: ______________________________
LAST FIRST MIDDLE

Mailing Address: ______________________________
STREET CITY STATE ZIP

Physical Address: ______________________________
STREET CITY STATE ZIP

Home Phone: ____________ Cell Phone: ____________ Birth Date: ____________ Social Security #: ____________

Patient Email: ______________________ Responsible Party Email: ______________________

Method of appointment reminder: ☐ Email ☐ Text: (_______)_______-______________/carrier: ______________

RESPONSIBLE PARTY INFORMATION

Name: ______________________________ Marital Status: ____________
LAST FIRST MIDDLE

Residence Address: ______________________________
STREET CITY STATE ZIP

Mailing Address: ______________________________
STREET/P.O. BOX CITY STATE ZIP

How long at this address: ____________ Home Phone: ____________ Work Phone: ____________

Cell Phone: ______________________ Alternate Phone: ______________________

Previous Address *(if less than 3 years)*: ______________________________
STREET CITY STATE ZIP

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

Employer: ______________________ No. Years Employed: ____________

Occupation: ______________________ Occupation No. ____________

Spouse's Name: ______________________ Relationship to Patient: ____________
LAST FIRST MIDDLE

Spouse's Employer: ____________ Occupation No. ____________ Years Employed: ____________

Spouse's Social Security #: ______________________ Spouse's Birth Date: ____________

INSURANCE INFORMATION

Insured's Name: ____________ DOB: ____________ Insured's Soc. Sec. #: ____________

Insurance Company: ______________________________

Group #: ______________________ Local No.: ______________________

Insurance Co. Address: ______________________________

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

Insured's Name: ____________ Birth Date: ____________ Insured's Soc. Sec. #: ____________

Insurance Company: ____________ Group #: ____________ Local No.: ____________

Insurance Co. Address: ______________________________

Insured's Employer: ______________________________

EMERGENCY INFORMATION

Name of nearest relative not living with you: ______________________________

Complete Address: ______________________________

Phone: ______________________ Relationship to Patient: ______________________

Signature: ______________________________ Date: ____________

I understand that where appropriate, credit bureau reports may be obtained. I understand and agree that I am responsible for payment. I certify this information is true and correct to the best of my knowledge.

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 examination.

Now or in the past, have you had:

☐ yes ☐ no ☐ dk/u Birth defects or 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 Polio, 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 problem?
☐ 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 condition?
☐ 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 substances (specify)____________________
☐ yes ☐ no ☐ dk/u Are you taking medication, nutrient supplements, herbal medications or non-prescription medicine? If yes, please name them:

Medication__________________ Taken for ____________________
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 health care professional?

If yes, for: ____

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

Describe: ____

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

Who may we thank for referring you to our office:

____

General Dentist's Name: ______________________________

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 congenitally missing teeth?
☐ yes ☐ no ☐ dk/u Chipped or otherwise injured primary (baby) or permanent teeth?
☐ yes ☐ no ☐ dk/u Teeth sensitive to hot or cold; teeth throb or ache?
☐ yes ☐ no ☐ dk/u Jaw fractures, cysts or mouth infections?
☐ 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 in 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 cheek, 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 Ever had a prior orthodontic examination or treatment?
☐ yes ☐ no ☐ dk/u Been under another dentist's care?
☐ yes ☐ no ☐ dk/u Been under another dental specialist's care?
☐ 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?

I understand the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical history.

Signature: ______________________________

Date: __________ Date: __________ Date: __________

Doctor: ______________________________

Date: __________ Date: __________ Date: __________