HERSHEY & HEYMANN
ORTHODONTICS
Simply Spectacular Smiles

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Medical Dental History Form

CONFIDENTIAL

PATIENT

Date_____

Patient's last name_____ First name_____ Middle initial_____

Title Mr. Mrs. Ms. Miss Dr. Other_____ I prefer to be called_____

Birth date_____ Sex: ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home address_____ City, State, Zip code_____

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

RESPONSIBLE PARTY

Full name_____ Relationship to patient_____

(If different from above) Address_____How long at this address_____

Previous address *(if less than 3 years)*_____

(*If different from above*) Home Phone_____ Cell phone_____ Work phone_____

Social Security Number_____ Birthdate_____ Email address_____

Employer_____ Occupation_____ # of years employed_____

Spouse's full name_____ Relationship to patient_____

Cell phone_____ Work phone_____

Social Security Number_____ Birthdate_____ Email address_____

Employer_____ Occupation_____ # of years employed_____

EMERGENCY CONTACT INFORMATION

Name_____ Relationship_____

Complete Address_____Phone_____

DENTIST

Patient's Dentist_____ Date of last cleaning and check-up_____

Other dentists/dental specialists being seen: Name_____ Reason_____

GENERAL INFORMATION

What concerns you about your teeth?_____

Who suggested that you may need orthodontic treatment?_____

Why did you select our office?_____

Describe any previous orthodontic treatment or consultations?_____

Have any other family members been treated in this office? Please name them_____

Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain._____

_____

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	
☐	☐	☐	Birth defects or hereditary problems?
☐	☐	☐	Bone fractures or major injuries?
☐	☐	☐	Any injuries to face, head, neck?
☐	☐	☐	Arthritis or joint problems?
☐	☐	☐	Cancer, tumor, radiation treatment or chemotherapy?
☐	☐	☐	Endocrine or thyroid problems?
☐	☐	☐	Diabetes or low sugar?
☐	☐	☐	Kidney problems?
☐	☐	☐	Stomach ulcer, hyperacidity, acid reflux?
☐	☐	☐	Immune system problems?
☐	☐	☐	History of osteoporosis?
☐	☐	☐	Gonorrhea, syphilis, herpes, sexually transmitted disease?
☐	☐	☐	AIDS or HIV positive?
☐	☐	☐	Hepatitis, jaundice, or other liver problems?
☐	☐	☐	Polio, mononucleosis, tuberculosis, pneumonia?
☐	☐	☐	Seizures, fainting spells, neurologic problems?
☐	☐	☐	Mental health disturbance or depression?
☐	☐	☐	History of eating disorder (anorexia, bulimia)?
☐	☐	☐	Frequent headaches or migraines?
☐	☐	☐	High or low blood pressure?
☐	☐	☐	Excessive bleeding or bruising, anemia?
☐	☐	☐	Chest pain, shortness of breath, tire easily, swollen ankles?
☐	☐	☐	Heart defects, heart murmur, rheumatic heart disease?
☐	☐	☐	Angina, arteriosclerosis, stroke, or heart attack?
☐	☐	☐	Skin disorder (other than common acne)?
☐	☐	☐	Vision or hearing problems?
☐	☐	☐	Frequent ear infections, colds, throat infections?
☐	☐	☐	Asthma, sinus problems, hayfever?
☐	☐	☐	Tonsil or adenoid condition?
☐	☐	☐	Do you frequently breathe through your mouth?
☐	☐	☐	Have you ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders?
☐	☐	☐	Do you eat a well balanced diet?

Have you had allergies or reactions to any or the following?

Yes	No	DK/U	
☐	☐	☐	Local anesthetics (novocaine, lidocaine, xylocaine)
☐	☐	☐	Latex (gloves, balloons)
☐	☐	☐	Ibuprofin (Motrin, Advil)
☐	☐	☐	Metals (jewelry, clothing snaps)
☐	☐	☐	Penicillin
☐	☐	☐	Other antiobiotics
☐	☐	☐	Acrylics
☐	☐	☐	Other substances _____

DENTAL HISTORY

Now or in the past, have you had:

Yes	No	DK/U	
☐	☐	☐	Permanent or extra (supernumerary) teeth removed?
☐	☐	☐	Supernumerary (extra) or congenitally missing teeth?
☐	☐	☐	Chipped or injured primary or permanent teeth?
☐	☐	☐	Any sensitive or sore teeth?
☐	☐	☐	Any broken or missing fillings?
☐	☐	☐	Bleeding gums, bad taste or mouth odor?
☐	☐	☐	Jaw fractures, cysts, infections?
☐	☐	☐	Any teeth treated with root canals or pulpotomies?
☐	☐	☐	"Gum boils," frequent canker sores or cold sores?
☐	☐	☐	History of speech problems or speech therepy?
☐	☐	☐	Difficulty breathing through nose?
☐	☐	☐	Mouth breathing habit or snoring at night?
☐	☐	☐	Food impaction between the teeth?
☐	☐	☐	Frequent oral habits (sucking finger, chewing pen, etc)?
☐	☐	☐	Teeth causing irritation to lip, cheek, or gums?
☐	☐	☐	Abnormal swallowing (tongue thrust)?
☐	☐	☐	Tooth grinding or clenching?
☐	☐	☐	Clicking, locking in jaw joints?
☐	☐	☐	Soreness in jaw muscles or face muscles?
☐	☐	☐	Ringing in ears, difficulty in chewing or opening jaw?
☐	☐	☐	Have you ever been treated for "TMJ" or "TMD" problems?
☐	☐	☐	Any serious trouble associated with previous dental treatment?
☐	☐	☐	Have you ever been diagnosed with gum disease?

PATIENT HEALTH INFORMATION

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

Medication_____ Taken for_____

Medication_____ Taken for_____

Medication_____ Taken for_____

Medication_____ Taken for_____

Have you ever taken any medications to strengthen your bones? Please describe._____

_____

Do you or have you ever had a substance abuse problem?_____

Do you chew or smoke tobacco?_____

Have you noticed any changes in your face or jaws?_____

Any other physical problems?_____

Women: Are you pregnant? ☐ Yes ☐ No Are you trying to become pregnant? ☐ Yes ☐ No

PHYSICIAN

Patient's Physician_____ City, State_____

Other physicians/health care providers being seen now:

Name_____ City, State_____

Reason_____

DENTAL INSURANCE

Primary policy holder's full name_____Birth date_____

Social security #_____ Relationship to patient_____

Address and phone *(if not listed on page 1)*_____

Insurance company_____ Group #_____ ID#_____

Insurance company address_____

Employer_____ Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't know

Secondary policy holder's full name_____Birth date_____

Social security #_____ Relationship to patient_____

Address and phone *(if not listed on page 1)*_____

Insurance company_____ Group #_____ ID#_____

Insurance company address_____

Employer_____ Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't know

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.

Signature_____ Date_____

I understand that where appropriate, credit bureau reports may be obtained.

Signature_____ Date_____