American Association of **Orthodontists**

Medical Dental History Form for Adult Patients

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   Social Security# _____

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

Home address _____   City, State, Zip code _____

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

Email Address(es) _____

Occupation _____   Employer _____

CLOSEST RELATIVE

Spouse or closest relatives name(s) _____

Title   Mr. Mrs. Ms. Miss. Dr. Other _____   Relationship to patient _____

Address (if different than patient address) _____

Home Phone (If different) (____) _____-_____   Cell phone (____) _____-_____   Work phone (____) _____-_____

DENTIST

Patient's Dentist _____   Address, City, State_____

Last seen _____   Reason _____   Next appointment _____

Other dentists/dental specialists now being seen: Name_____ City, State _____

Reason_____

PHYSICIAN

Patient's Physician _____   City, State _____

Last seen _____   Reason _____   Next appointment _____

Most recent physical exam _____

Other physicians/health care providers being seen now:

Name_____   City, State _____

Reason _____

Name_____   City, State _____

Reason _____

GENERAL INFORMATION

What concerns you about your teeth?_____

Who suggested that you might need orthodontic treatment? _____

Why did you select our office? _____

Have you had any previous orthodontic treatment? Please describe. _____

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. _____

_____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____

Address *(if different than page 1)* _____ City, State, Zip_____

Home phone (   ) _____-_____   Cell phone (   ) _____-_____   Email address(es) _____

Social Security #_____   Employer _____

DENTAL INSURANCE

Primary policy holder's full name _____ Birth date _____

Social Security #_____   Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____   Address _____

Insurance company_____   Group # _____ ID# _____

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 above) _____

Employer _____   Address _____

Insurance company_____   Group # _____ ID# _____

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

MEDICAL INSURANCE

Policy holder's full name _____

Insurance Company _____