



CONFIDENTIAL

Medical Dental History Form for 26 and Over

PATIENT

Date _____ Social Security # _____
Patient's last name _____ First name _____ Middle initial _____ Title
Mr. Mrs. Miss Dr. Other I prefer to be called _____ Birth date _____ What sex were
you assigned on your birth certificate? Male Female What is your current gender identification? Male Female Other What are your
preferred pronouns? _____ Marital Status Single Married Separated Divorced Widowed
Home address _____ City, State, Zip code _____ Cell
phone _____ Home phone _____ Work phone _____ E-mail
address(es) _____
Occupation _____ Employer _____

CLOSEST RELATIVE

Spouse or closest relative's name(s) _____ Relationship to patient _____ Title
Mr. Mrs. Miss Dr. Other Prefers to be called _____ Address (if different than
patient address) _____ Cell phone
_____ Home phone _____ Work phone _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____
Address _____ City, State, Zip _____
Cell phone _____ Home phone _____
E-mail address(es) _____
Social Security # _____ Employer _____

DENTAL INSURANCE

Primary policy holder's full name _____ Birthdate _____ 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 _____ Birthdate _____
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 _____

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. _____

PATIENT HEALTH INFORMATION

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

Do you take antibiotic pre-medication before any dental procedures? ☐ Yes ☐ No

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 currently suffer with, or have you suffered in the past with an eating disorder? _____

Have you chewed tobacco ☐ Yes ☐ No or smoked any substance or vaped? ☐ Yes ☐ No

If yes, what is the frequency? _____

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

Any other physical problems? _____

How often do you brush? _____ How often do you floss? _____

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

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 mark yes, no, or don't know/understand (dk/u).

MEDICAL HISTORY

Now or in the past, have you had:

Yes No DK/U

- ☐ ☐ ☐ Have you ever taken intravenous medication for bone disorders or cancer such as bisphosphonates as Zometa (zoledronic acid), Aredia (pamidronate) or Didronel (etidronate)?
- ☐ ☐ ☐ Have you ever taken oral medication for bone disorders such as bisphosphonates Fosamax (alendronate), Actonel (risedronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate)?
- ☐ ☐ ☐ Hereditary or developmental conditions?
- ☐ ☐ ☐ Bone fractures, or major injuries?
- ☐ ☐ ☐ Any injuries to face, head, neck?
- ☐ ☐ ☐ Arthritis or joint problems?
- ☐ ☐ ☐ Endocrine or thyroid problems?
- ☐ ☐ ☐ Diabetes or low sugar?
- ☐ ☐ ☐ Kidney problems?
- ☐ ☐ ☐ Cancer, tumor, radiation treatment or chemotherapy?
- ☐ ☐ ☐ Stomach ulcer, hyperacidity, acid reflux?
- ☐ ☐ ☐ Immune system problems?
- ☐ ☐ ☐ History of osteoporosis?
- ☐ ☐ ☐ Gonorrhea, syphilis, herpes, sexually transmitted diseases?
- ☐ ☐ ☐ AIDS or HIV positive?
- ☐ ☐ ☐ Hepatitis, jaundice or other liver problem?
- ☐ ☐ ☐ Polio, mononucleosis, tuberculosis, pneumonia?
- ☐ ☐ ☐ Seizures, fainting spells, neurologic problem?
- ☐ ☐ ☐ Mental health disturbance or depression?
- ☐ ☐ ☐ Vision, hearing, or speech problems?
- ☐ ☐ ☐ History of eating disorder (anorexia, bulimia)?
- ☐ ☐ ☐ Have you experienced any weight change in the past several months?
- ☐ ☐ ☐ 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)?
- ☐ ☐ ☐ Do you eat a well-balanced diet?
- ☐ ☐ ☐ Frequent headaches or migraines?
- ☐ ☐ ☐ Frequent ear infections, colds, throat infections?
- ☐ ☐ ☐ Asthma, sinus problems, hayfever?
- ☐ ☐ ☐ Tonsil or adenoid condition?
- ☐ ☐ ☐ Do you frequently breathe through your mouth?

Have you had allergies or reactions to any of the following:

Yes No DK/U

- ☐ ☐ ☐ Latex (gloves, balloons)
- ☐ ☐ ☐ Metals (jewelry, clothing snaps)
- ☐ ☐ ☐ Acrylics
- ☐ ☐ ☐ Local anesthetics (novocaine, lidocaine, xylocaine)
- ☐ ☐ ☐ Aspirin
- ☐ ☐ ☐ Ibuprofen (Motrin, Advil)
- ☐ ☐ ☐ Penicillin
- ☐ ☐ ☐ Other antibiotics
- ☐ ☐ ☐ Plant pollens

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?
- ☐ ☐ ☐ 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 therapy?
- ☐ ☐ ☐ Difficulty breathing through nose?
- ☐ ☐ ☐ Food impaction between the teeth?
- ☐ ☐ ☐ Mouth breathing habit or snoring at night?
- ☐ ☐ ☐ History of speech problems?
- ☐ ☐ ☐ 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 broken or missing fillings?
- ☐ ☐ ☐ Any serious trouble associated with previous dental treatment?
- ☐ ☐ ☐ Have you ever been diagnosed with gum disease or pyorrhea?
- ☐ ☐ ☐ Have you ever had an orthodontic consultation or treatment before now?

FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders _____

Diabetes _____

Arthritis _____

Severe allergies _____

Unusual dental problems _____

Jaw size imbalance _____

Other family medical conditions? _____

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature _____ Date _____

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 _____

MEDICAL HISTORY UPDATES OR CHANGES

Changes _____

Patient Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Patient Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Patient Signature _____ Date _____

Dental Staff Signature _____ Date _____

**PATIENT AUTHORIZATION FOR SPECIFIC DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

I, the undersigned, hereby authorize Quad City Orthodontics to disclose certain protected health information about me to:

(Name)

(Address)

Quad City Orthodontics is hereby authorized to disclose the following protected health information (specifically describe the information to be disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

☐ All Medical Records ☐ x-Rays ☐ Specific Information Listed Below:

I understand that this request does not apply to: (1) certain health information that is not held in Quad City Orthodontics' medical records; (2) psychotherapy notes; (3) information compiled in reasonable anticipation of or for litigation; and (4) other health information not subject to the right of access under HIPAA.

The information may be disclosed for the following purpose(s):

This authorization will expire 90 days after the date of its execution or on _____
(name specific date or event), unless expressly revoked by me at an earlier time.

My signature below acknowledges that I understand that:

- I have the right to inspect or obtain a copy of the information to be disclosed.
- This request does not apply to certain health information that is not held in Quad City Orthodontics' medical records.
- This request does not apply to information or records compiled in reasonable anticipation of litigation.
- This request does not apply to any other health information not subject to the right of access under HIPAA.
- I may refuse to sign or, at any time, may revoke this Authorization for any reason. I understand that if I revoke this authorization, I must do so by sending a written notice of revocation to _____, and that such refusal or revocation will not affect the commencement, continuation, or quality of my treatment. I understand that the revocation will not apply to information that has already been released in response to this authorization. This Authorization will remain in effect until the term of

this Authorization specified herein expires or I provide a written notice of revocation for this Authorization.

- I understand that Quad City Orthodontics may not condition my treatment on whether I sign this authorization.
- I understand that if my protected health information is disclosed to someone who is not required to comply with the federal HIPAA regulations, then such information may be re-disclosed by the recipient and may no longer be protected by HIPAA.

I authorize the disclosure described herein. I have read and understand this authorization. I am the patient listed on this authorization or am authorized to act on behalf of the patient as the patient's personal representative. **I hereby release Quad City Orthodontics profrom all legal responsibility of liability that may arise from the act I have authorized above.** I understand copying fees may apply and agree to pay such cost on receipt.

ATTENTION: Once the above information has been released pursuant to this Authorization, it may no longer be protected by Federal and/or State laws or regulations; and may no longer be deemed "Confidential".

Signature of Patient or Legal Guardian: _____		Date: _____	
Patient Name: _____		SS# _____	
Address: _____		City: _____	State: _____ Zip: _____
DOB: _____		Phone: _____	
Printed Name of Patient or Legal Guardian: _____			
Witness: _____			

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION