Medical Dental History Form

seligman orthodontics PLLC

Date_____

Confidential Patient Information

Patient's Name _____
Last First Middle

Address_____
Street City State Zip

Home Phone_____ Birthdate_____ Social Security #_____

If patient is a minor, give parent's or guardian's name_____

Whom may we thank for referring you to our office?_____

Confidential Responsible Party Information

Name _____ Marital Status_____
Last First Middle

Residence_____ ☐Own ☐Rent
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address_____ Home Phone_____ Work Phone_____

Previous Address (if less than 3 yrs.)_____
Street City State Zip

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. Years Employed_____

Spouse's Name_____ Relationship to Patient_____
Last First Middle

Employer_____ Occupation_____ No. Years Employed_____

Social Security #_____ Birthdate_____ Work Phone_____

Insurance Information

Policy Holder's Name _____ and Social Security #_____

Insurance Company_____ Group No._____ Union Local No._____

Insurance Comapny Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____

Do you have dual coverage? No ☐ Yes ☐ If yes:

Policy Holder's Name_____ and Social Security #_____

Insurance Company_____ Group No._____ Union Local No._____

Insurance Co. Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____

Emergency Information

Name of nearest relative not living with you_____

Complete Address_____

Phone_____ Relationship:_____

I understand that where appropriate, credit bureau reports may be obtained.
Signature (Parent's signature if minor)_____

Updates (date & initial)_____

CONFIDENTIAL (for record and pretreatment evaluation)

PATIENT NAME_____ **DATE**_____

MEDICAL HISTORY

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 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?
☐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, 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 depression?
☐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 Tired 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 have 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 Hayfever, asthma, sinus trouble or hives?
☐yes ☐no ☐dk/u Tonsil or adenoid conditions?
☐yes ☐no ☐dk/u Osteoporosis?

Allergies or reactions to any of the following:

☐yes ☐no ☐dk/u Local anesthetics (Novocaine or Lidocaine)
☐yes ☐no ☐dk/u Asprin
☐yes ☐no ☐dk/u Ibuprofen (Motrin, Advil)
☐yes ☐no ☐dk/u Penicillin or other antibiotics
☐yes ☐no ☐dk/u Sulfa drugs
☐yes ☐no ☐dk/u Codeine or other narcotics
☐yes ☐no ☐dk/u Metals (jewelry, clothing snaps)
☐yes ☐no ☐dk/u Latex (gloves, balloons)
☐yes ☐no ☐dk/u Vinyl
☐yes ☐no ☐dk/u Acrylic
☐yes ☐no ☐dk/u Animals
☐yes ☐no ☐dk/u Foods (specify) _____
☐yes ☐no ☐dk/u Other substances (specify) _____
☐yes ☐no ☐dk/u Are you taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them

Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
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 chew or smoke tobacco?
☐yes ☐no ☐dk/u Operations? Describe: _____
_____
☐yes ☐no ☐dk/u Hospitalized? Describe: _____
_____
☐yes ☐no ☐dk/u Other physical problems or symptoms?
Describe: _____
_____
_____

☐yes ☐no ☐dk/u Being treated by another health care professional?

For:_____

Date of most recent physical exam? _____

Do you have any other medical conditions that we should know about?

_____

_____

_____

WOMEN ONLY

☐yes ☐no ☐dk/u Are you pregnant?

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

FAMILY MEDICAL HISTORY

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

Bleeding disorders _____

Diabetes _____

Arthritis _____

Severe allergies _____

Unusual dental problems _____

Jaw size imbalance _____

Any other family medical conditions that we should know about? _____

_____

_____

DENTAL HISTORY

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 Peiodontal "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 or jaw clenching?

☐yes ☐no ☐dk/u Any pain, clicking or locking 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 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 teeth 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?

Specialist _____

Other _____

☐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?

How often do you brush: _____ Floss: _____

What is your primary concern? Why are you here? _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____
Street City State Zip

Phone _____ Relationship to patient _____

SIGNATURES & INITIALS

1. _____ I have read and understand the above questions. 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. If there are any changes later to this history record or medical/dental status, I will so inform this practice.
2. _____ I authorize release of any information leading to insurance claims for this patient and authorize payment directly to Dr. David H. Seligman DMD, PC, of the group insurance benefits.

Patient Signature: _____ Date Signed: _____

Staff Member Signature: _____ Date Signed: _____

MEDICAL HISTORY UPDATE OR CHANGES

Comments: ____

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Patient Signature: ______________________ Date Signed: __________

Staff Member Signature: ______________________ Date Signed: __________

MEDICAL HISTORY UPDATE OR CHANGES

Comments: ____

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Patient Signature: ______________________ Date Signed: __________

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MEDICAL HISTORY UPDATE OR CHANGES

Comments: ____

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Patient Signature: ______________________ Date Signed: __________

Staff Member Signature: ______________________ Date Signed: __________