BRAND ORTHODONTICS

ADAM J. BRAND ▪ DDS ▪ MS ▪ APC

MEDICAL/DENTAL HISTORY FORM - ADULT

Date _____/_____/_____

PATIENT INFORMATION

Patient's Name _____ I prefer to be called_____
Last First Middle

Birth Date _____/_____/_____ Age _____ Gender: Male Female

Address _____

City_____ Zip_____

Home Phone #_____ Cell #_____

SS# _____ e-mail _____

Referred by_____

Dentist_____

Address_____

Phone #_____

Physician_____

Address_____

Phone # _____

RESPONSIBLE PARTY INFORMATION

Patient's Occupation_____

Employer_____

Employer Address_____

City_____ Zip_____ Work Ph #_____

Do you or your spouse have dental insurance covering orthodontics? YES NO

Other responsible party_____ Phone_____

Spouse's Name_____

SS #_____ Birth Date _____/_____/_____

Employer/Occupation_____

Address_____

City_____ Zip_____ Work Ph#_____

Address_____ City/State_____ Zip_____

DENTAL HISTORY

What is your main concern? _____

_____

Is there a family history of orthodontic problems? _____

Were there any habits which have caused the teeth to move? (i.e.: biting fingernails or lip, thumb sucking, etc.)? _____

Has an orthodontist been consulted previously? _____

Any injuries to face, mouth, or teeth in the past?	YES	NO	Are you self-conscious about the appearance of your teeth?	YES	NO
Are there any missing or extra permanent teeth?	YES	NO	Do you have any speech problems?	YES	NO
Do you have teeth clenching or grinding habits?	YES	NO	Do you have sore or sensitive teeth?	YES	NO
Does your jaw ever click or pop?	YES	NO	How often do you brush your teeth (per day)? _____		
Have you had pain in the jaws, ears or face?	YES	NO	When was your last professional dental cleaning? _____		
Have you ever had any orthodontic treatment?	YES	NO	How often are your cleanings scheduled? _____		

Additional information:_____

_____

_____

Are you currently taking or have ever taken any oral or intravenous bisphosphonates for serious bone disorders/cancers; such as Fosamax (alendronate), Actonel (risendronate), Boniva (ibandronate), Skelid (tiludronate), Didronel (etidronate Zometa (alendronate), Aredia (pamidronate), Didronel (etidronate)? YES NO

If yes, describe: _____

_____

Please complete the back of this form

MEDICAL HISTORY

Date of last medical care/physical _____

Have you been hospitalized in the last 2 years? YES NO If yes, reason: _____

Your health is: Excellent Good Fair Poor

For the following, please circle YES or NO. Please describe any YES answers below under Remarks.

1. Allergies			9. Fainting	YES	NO
a. Penicillin	YES	NO	10. Glandular disease (thyroid, etc.)	YES	NO
b. Other Antibiotics	YES	NO	11. Heart disease	YES	NO
c. Local Anesthetics	YES	NO	12. Heart murmur	YES	NO
d. Metals	YES	NO	13. Rheumatic fever	YES	NO
e. Vinyl	YES	NO	14. High blood pressure	YES	NO
f. Latex (gloves, balloons)	YES	NO	15. Low blood pressure	YES	NO
g. Acrylic	YES	NO	16. Kidney disease	YES	NO
h. Others_____	YES	NO	17. Liver disease, Hepatitis, Jaundice	YES	NO
2. Arthritis	YES	NO	18. Psychiatric treatment	YES	NO
3. Asthma	YES	NO	19. Radiation treatment	YES	NO
4. Blood disease or Abnormal Bleeding Problems	YES	NO	20. Respiratory disease	YES	NO
a. Anemia	YES	NO	21. Stomach or Duodenal ulcers	YES	NO
b. Clotting Problems	YES	NO	22. Tumor history	YES	NO
c. Other Blood Disorders_____	YES	NO	23. Venereal disease	YES	NO
5. Diabetes	YES	NO	24. A.I.D.S/HIV +	YES	NO
a. Any immediate family history?	YES	NO	25. Other Medical Conditions _____		
6. Bone Disorders	YES	NO	_____		
7. Epilepsy	YES	NO	26. Emotional/Behavioral problems_____		
8. Chest pains, ankle swelling, or shortness of breath?	YES	NO	_____		

26. Do you chew or smoke tobacco? YES NO
27. Have you had excessive bleeding requiring treatment? YES NO
28. Are you taking medications, nutrient supplements, drugs or pills regularly? YES NO If 'YES', please name: _____
_____
29. Have you experienced any unfavorable reaction to previous dental treatment? YES NO
30. Do you require pre-medication, based on physician instruction/personal reference, prior to dental treatment? YES NO
If 'YES", name of medication(s) _____
31. Is there any other information we should know? _____
32. **Women only**:
    a. Are you pregnant? YES NO
    b. Are you anticipating becoming pregnant? YES NO

REMARKS _____

_____

I have read and understand the above questions. I am 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.

Signed: _____ Date: _____ Updated: _____
(Patient)

Signed: _____ Date: _____ Updated: _____
(Doctor)

10425 Tierrasanta Blvd., Ste 205
San Diego, CA 92124
tel. 858-560-6374
fax. 858-560-6174

9728 Carmel Mountain Rd., Ste F
San Diego, CA 92129
tel. 858-484-1333
fax. 858-484-7820

WWW.BRANDORTHODONTICS.COM