



Adult History Form

Full Name: \_\_\_\_\_ Like to be called: \_\_\_\_\_ Sex: M F Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Phone number of responsible party: \_\_\_\_\_

Address of responsible party: \_\_\_\_\_ Email: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_ Family we have seen: \_\_\_\_\_

- Yes No Are you in good health? \_\_\_\_\_
- Yes No Do you have any medical condition? What? \_\_\_\_\_
- Yes No Do you take any medicine? What? \_\_\_\_\_
- Yes No Do you have any allergies to medicines, latex, or nickel? What? \_\_\_\_\_
- Yes No Have you ever had any surgery or hospitalizations? For what? \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Do you have, or have you ever had any of the following:

- |     |    |                       |     |    |                     |     |    |                                     |
|-----|----|-----------------------|-----|----|---------------------|-----|----|-------------------------------------|
| Yes | No | Heart Disease         | Yes | No | Hepatitis           | Yes | No | Allergy to latex                    |
| Yes | No | Rheumatic fever       | Yes | No | HIV/AIDS            | Yes | No | Allergy to Nickel                   |
| Yes | No | Heart Murmur          | Yes | No | Do you smoke?       | Yes | No | Osteoporosis / Bone Cancer Medicine |
| Yes | No | Mitral Valve Prolapse | Yes | No | Allergies/ Hayfever |     |    |                                     |

Dentist: \_\_\_\_\_ Last dental visit: \_\_\_\_\_

- Yes No Have there been any injuries to the face, mouth, or teeth? \_\_\_\_\_
- Yes No Have you ever sucked a thumb or finger? Until what age? \_\_\_\_\_
- Yes No Any missing or extra permanent teeth? \_\_\_\_\_
- Yes No Has an orthodontist been consulted previously? Who? \_\_\_\_\_
- Yes No Do you clench or grind the teeth at night? \_\_\_\_\_
- Yes No Do you have a click or pop of the jaw joint? \_\_\_\_\_
- Yes No Do you have or ever had any jaw pain? \_\_\_\_\_
- Yes No Do you have gum disease or had any previous gum treatment? \_\_\_\_\_

What are your primary concerns? \_\_\_\_\_

I, the undersigned, have given the information, have reviewed it, and find it accurate and complete. I consent to the use of photographs for marketing/educational purposes.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_