Medical Dental History Form

For Adult Patients

Name: _____

(Last) (First) (Middle) Mr Mrs Ms Dr

I prefer to be called: _____ **Male** _____ **Female** _____ **Birthdate** _____/_____/_____

Age: _____ **SS#:** _____ **Single**_____ **Married**_____ **Divorced**_____ **Separated**_____ **Widowed**_____

Address: _____

Street City State Zip

Home Phone: (_____**)** _____ **Cell: (**_____**)** _____ **Work: (**_____**)** _____ **Ext:** _____

Email Address: _____

Employer: _____ **How long there?** _____**Occupation:** _____

Employer's Address: _____

Street City State Zip

Spouse's Name: _____ **Phone #:** _____

Name of nearest relative or friend not living with you: _____

Their relation to you: _____ **Their phone #:** _____

How did you hear about our office? Internet Insurance Co. Dentist
Friend-Who? _____ **Other** _____

Orthodontic Insurance Information

Dental Coverage: _____**Yes** _____**No** **Dental Insurance Co.:** _____

ID # _____ **Group #** _____ **Phone # (**_____**)** _____

Insurance Co. Address: _____

Insurance Subscriber's Name: _____**Their Birthdate**_____

Their relation to you: _____ **Their SS#** _____ **Employer** _____

Release and Waiver

I authorize release of any information regarding my orthodontic treatment to my dental 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 completion of this form. I will notify my orthodontist of any changes in my medical/dental health.

Signature _____ **Date** _____

3019-B North Druid Hills Rd NE Atlanta, GA 30329 Office (404) 417-0771 Fax (404) 417-0772
990-B Whitlock Ave NW Marietta, GA 30064 Office (770) 670-6916 Fax (678) 426-3226
www.drwrightortho.com

Medical History

Circle any of the following medical conditions you have or are currently being treated for:

Congenital Heart Defect	**Heart Murmur**	**Herpes**	**Mitral Valve Prolapse**	**Pregnancy**
Epilepsy	**Hepatitis**	**HIV/AIDS**	**Mouth Ulcers**	

List any medical conditions not listed that you feel we should be aware of:

_____

_____

_____

Circle any allergic reactions to the following:

Latex **Jewelry/Metals** **Vinyl** **Plastics**

Other: _____

Dental History

Dentist Name: _____ **Date of last visit:** _____/_____/_____

What concerns do you have about your teeth:

_____

_____

YES **NO** **Do you have any type of thumb or tongue habit?**

YES **NO** **Do you tend to breathe through your mouth?**

YES **NO** **Have you ever had Orthodontic treatment before?**

YES **NO** **Do you clench or grind your teeth?**

YES **NO** **Does your jaw click, pop, or hurt?** **If yes, please explain:** _____

Benefits of Orthodontics

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Wright to perform a complete orthodontic evaluation.

Signature: _____ **Date:** _____

Wright ORTHODONTICS

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