PHOENIX
ORTHODONTICS

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Tualatin, OR 97062

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Adult Medical History

Today's Date _____ ☐Male ☐Female
Name _____ Mr Mrs Ms Dr
Last First MI
SS # _____
Birthdate _____ Age _____
Home Address _____
_____
City State Zip
Home # _____ E-mail _____
Work# _____
☐Single ☐Married ☐Divorced ☐Widowed ☐Separated
Occupation _____
Employer _____ How Long? _____
Employer's address _____
Where/When is the best time to reach you? _____
How did you hear about us? _____
Other family members seen by us: _____
_____
In the event of an emergency who should we contact?
_____ Phone # _____

Spouse / Other Information

His/ Her Name _____
Employer _____
Work # _____ Home # _____
SS # _____ Birthdate _____

General Dentist _____
Date of last check-up/cleaning: _____

What are your main concerns that you would like orthodontics to accomplish? _____
_____

Have you ever been evaluated or had orthodontic treatment before? ☐Yes ☐No
Have there been any injuries to the face, mouth, teeth or chin? ☐Yes ☐No
Have you ever been informed of any missing or extra permanent teeth? ☐Yes ☐No
Have you ever had any pain/tenderness in your jaw joint (TMJ/TMD)? ☐Yes ☐No
Have you ever had a difficult problem with any previous dental work? ☐Yes ☐No
Do you like your smile? ☐Yes ☐No
Do your gums ever bleed? ☐Yes ☐No
Do you generally breath through your mouth? ☐Yes ☐No

Are you currently under the care of a physician?
☐No ☐Yes; Please explain _____
Your Physician _____
Phone # _____ Date of last visit _____
Please describe your current physical health:
☐Good ☐ Fair ☐ Poor
Please list all drugs you are currently taking: _____
_____

Have you ever had any of these medical problems?

Y N Abnormal Bleeding
Y N Anemia
Y N Artificial Bones/ Joints/ Valves
Y N Asthma
Y N Arthritis
Y N Cancer/ Chemotherapy
Y N Congenital Heart Defects
Y N Convulsions/Epilepsy
Y N Diabetes
Y N Emphysema
Y N Drug/ Alcohol Abuse
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Fever Blisters/ Herpes
Y N Heart Murmur
Y N Heart Surgery/ Pacemaker
Y N Hemophilia
Y N Hepatitis
Y N HIV+/AIDS
Y N High/ Low Blood Pressure
Y N Hospitalization
Y N Kidney/Liver Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Sinus Problems
Y N Severe/ Frequent Headaches
Y N Operations
Y N Rheumatic Fever
Y N Hear Attack
Y N Ulcers/ Colitis
Y N Tuberculosis (TB)
Y N Venereal Disease

Are you pregnant? ☐No ☐Yes

Please list any medical problems that you have ever had:
_____
_____

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Penicillin
Y N Codeine	Y N Latex	Y N Dental Anesthetics
Y N Tetracycline	Y N Metals/ Plastics	Y N Other

I understand that this information is correct and will be held in confidence and it is my responsibility to inform this office of any changes in medical status.

I authorize the dental staff to perform the necessary dental services I may need, including diagnostic records (radiographs, impressions, photographs).

_____
Signature Date

_____
Reviewed Date