Cavanaugh & Nondorf Orthodontics

Medical/Dental History Form for Adult

Patients Last Name:______________ First:______________ Date:__________
Date of Birth: __________ Age:________ Sex:________ Home Phone:__________
Cell Phone:______________ Email:______________
Address:______________ City:______________ State:________ Zip:________
Social Security #:______________
Patient is: Single:________ Married:________ Widowed:________ Separated: ________ Divorced________
Spouses Name:______________
Name of Patient's Dentist: ______________ Referred By:______________
Occupation:______________ Employer:______________ Work Phone:__________
In case we cannot reach you: Person to contact______________ Phone #__________

Medical History

Health Quality: ☐ Good ☐ Fair ☐ Poor Allergies: ☐ Nickel ☐ Drug ☐ Other:______________

Has the patient had any of the following: (Please Circle)

Jaw Noises/Pain	Diabetes	Kidney Problems	Sinus Problems	Immune Disorder	Lip or Tongue Biting
Frequent Headaches	Heart Disease	Bleeding Gums	Arthritis	Speech Impairment	Nail Biting
Snoring	Epilepsy	Liver Disease	Convulsions/Seizures	Tonsils/Adenoids	Asthma
Rheumatic Fever	Excessive Bleeding	Cold Sores/Fever Blisters	Dental Anesthetic Sensitive	Mouth Breathing	Hemophilia
Gag Easily	Thyroid Problems	Dizziness or Fainting	Grinding of Teeth	Thumb/Finger Sucking	Difficult Breathing
Latex Sensitivity	Artificial Joints	AIDS/HIV	Radiation Therapy	Chemotherapy	Sleep Apnea

Other Medical Concerns:______________________________
____
Physician:______________ Under Physician's Care at Present? (Y or N)______________
For What:______________________________
List Drugs Regularly Taken & Reason:______________________________

Dental History

Last Dental Visit:__________ Dental Work Being Done Now?________ If Yes What?______________
Has Patient Ever Received a Blow to the Teeth or Jaw?________ If Yes, Explain:______________
Has the Patient had Orthodontic Treatment or Evaluation?________ If Yes, By Whom?______________
Family Members in Treatment? ______________
Family Members with history of jaw surgery or underbite? ______________
What do you feel are the Orthodontic Problems? ☐ Alignment of Teeth ☐ Dental Protrusion ☐ Facial Features
Other:______________________________
Who First Noticed the Need for Orthodontic Treatment?______________________________

How did you hear about us? (Please check all that apply): ☐ Internet Search (ex//Google):__________ ☐ Website: __________
☐ Insurance plan ☐ Dentist ☐ Facebook ☐ Friend: __________ ☐ Other: ______________

Orthodontic Insurance

Primary	Secondary
Insured's Social Security #:______________	Insured's Social Security #:______________
Lifetime Maximum Benefit: ______________	Lifetime Maximum Benefit: ______________
Insurance Co. Name: ______________	Insurance Co. Name:______________
Insurance Co. Address:______________	Insurance Co. Address:______________
Insurance Co. Phone #:______________	Insurance Co. Phone #:______________
Group # (plan or policy #):______________	Group # (plan or Policy #):______________
Insured's Name:______________	Insured's Name:______________
Insured's Relation to Patient:______________	Insured's Relation to Patient:______________
Insured's Date of Birth:______________	Insured's Date of Birth:______________
Insured's Employer:______________	Insured's Employer:______________

I certify that I have answered the above questions to the best of my ability. I will not hold Cavanaugh and Nondorf Orthodontics, P.C. or any member of its staff responsible for any errors or omissions that I may have made in the completion of this form. I will take full financial responsibility for any and all records taken, and will pay the cost of x-rays and other records taken at the time of consultation and/or diagnosis.

______________________________ ______________
Signature of Patient (Parent or Guardian if Patient is a Minor) Date