



# TheBracePlace

JAMES IAN BALLOU, DDS

## CONFIDENTIAL MEDICAL DENTAL HISTORY FOR ADULT PATIENTS

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Who can we thank for referring you to our office? \_\_\_\_\_

Patient's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male  Female  I Prefer to be Called: \_\_\_\_\_

S.S.N./S.I.N.: \_\_\_\_\_ Home Phone No.: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

Years at above address: \_\_\_\_\_ If less than 5 years, previous address: \_\_\_\_\_

Patient is: Single  Married  Widowed  Separated  Divorced

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Years with employer: \_\_\_\_\_

Business Phone No: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Name of Spouse/Closest Relative: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Spouse/Relative Contact #: \_\_\_\_\_

Dentist's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Physician's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

PERSON OR PERSONS RESPONSIBLE FOR ACCOUNT: \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

Name of Insured: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

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

Work Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Group #: \_\_\_\_\_

Address: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Name of Insured: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

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

Work Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Group #: \_\_\_\_\_

Address: \_\_\_\_\_

**MEDICAL HISTORY : Now or in the past, have you had:**

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Birth defects or hereditary problems?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Bone fractures, any major accidents?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Rheumatoid or arthritic conditions?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Endocrine or thyroid problems?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Kidney problems?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Diabetes?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Cancer, tumor, radiation treatment or chemotherapy?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Stomach ulcer or hyperacidity?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Polio, mononucleosis, tuberculosis or pneumonia?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Problems of the immune system?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	AIDS or HIV positive?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Hepatitis, jaundice or liver problems?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Fainting spells, seizures, epilepsy or neurological problem?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Mental health disturbance or behavioral problem?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Vision, hearing, tasting or speech difficulties?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Loss of weight recently, poor appetite?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	History of eating disorder (anorexia, bulimia)?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Bleeding disorder, bruising tendency, excessive bleeding or anemia?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	High or low blood pressure?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Tires easily?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Chest pain, shortness of breath or swelling ankles?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Skin disorder?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Does the patient eat a well-balanced diet?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Frequent headaches, colds or sore throats?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Eye, ear, nose or throat condition?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Hayfever, asthma, sinus trouble or hives?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Tonsil or adenoid conditions?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Osteoporosis?

**Allergies or reactions to any of the following:**

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Local anesthetics (Novocaine or Lidocaine)
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Aspirin
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Ibuprofen (Motrin, Advil)
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Penicillin or other antibiotics
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Sulfa drugs
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Codeine or other narcotics
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Metals (jewelry, clothing snaps)
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Latex (gloves, balloons)
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Vinyl
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Acrylic
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Animals
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Foods (specify) _____
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Other substances (specify) _____

Yes  No Are you taking medication, nutrient supplements, herbal medications or non-prescription medicine? Please name them.

Medication: \_\_\_\_\_ Taken for: \_\_\_\_\_

Medication: \_\_\_\_\_ Taken for: \_\_\_\_\_

Medication: \_\_\_\_\_ Taken for: \_\_\_\_\_

Medication: \_\_\_\_\_ Taken for: \_\_\_\_\_

Yes  No Do you currently have or ever had a substance abuse problem?

Yes  No Do you chew or smoke tobacco?

Yes  No Operations? (specify) \_\_\_\_\_

Yes  No Hospitalized? (for) \_\_\_\_\_

Yes  No Other physical problems or symptoms? (describe) \_\_\_\_\_

Yes  No Being treated by another health care professional? (for) \_\_\_\_\_

Date of most recent physical exam: \_\_\_\_\_

Yes  No Are there any other medical conditions that we should be aware of?  
\_\_\_\_\_

**WOMEN ONLY**

Yes  No Are you pregnant?  
 Yes  No Are you anticipating becoming pregnant?

I have read and understand the above questions. I will not hold my orthodontist or any staff member 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 signed: \_\_\_\_\_  
(Patient)

Signed: \_\_\_\_\_ Date signed: \_\_\_\_\_  
(Dental Staff Member)

**DENTAL HISTORY: Now or in the past, have you had:**

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Permanent or "extra" (supernumerary) teeth removed?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Supernumerary (extra) or congenitally missing teeth?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chipped or otherwise injured teeth?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Teeth sensitive to hot or cold; throb or ache?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Jaw fractures, cysts or mouth infections?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	"Dead teeth" or root canals treated?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bleeding gums, bad taste or mouth odor?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Periodontal "gum" problems?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Food impaction between teeth?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thumb, finger, or sucking habit? Until what age? _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Abnormal swallowing habit (tongue thrust)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	History of speech problems?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mouth breathing habit, snoring or difficulty in breathing?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tooth grinding, jaw clenching, clicking or locking?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any pain in jaw or ringing in the ears?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any pain or soreness in the muscles of the face or around the ears?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Difficulty in chewing or jaw opening?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any loose, broken, or missing fillings?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Concerns about your profile?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Concerns about spaced, crooked or protruding teeth?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Aware or concerned about under or over developed jaw?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	"Gum Boils," canker sores or cold sores?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Taking any forms of fluoride?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any relative with similar tooth or jaw relationships?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Had periodontal (gum) treatment?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Would you object to wearing orthodontic appliances (braces) should they be indicated?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any serious trouble associated with any previous dental treatment?

How often do you brush: \_\_\_\_\_ floss: \_\_\_\_\_

Yes  No Have you ever had a prior orthodontic examination or treatment?

Doctor's name: \_\_\_\_\_ Date of treatment: \_\_\_\_\_

What is your primary concern? Why are you here? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Signed: \_\_\_\_\_ Date signed: \_\_\_\_\_  
(Patient)

Signed: \_\_\_\_\_ Date signed: \_\_\_\_\_  
(Dental Staff Member)