BIERMANN ORTHODONTICS

*Exceptional Smiles for Children and Adults*

# Adult Health History

Full Name _____ Male ❑ Female ❑

Name you prefer? _____Date of Birth _____ Age _____

Your HOME Address _____

City _____ State _____ Zip _____

Email address (for appointment reminders) _____

Home Phone: _____Cell Phone: _____

Work Phone: _____
We send email appointment reminders, and also offer text message or phone call reminders upon request.

Your occupation or job description_____

Employer _____

Spouse/Partner name _____

Spouse/Partner email address _____

Spouse/Partner Cell Phone: _____ Work Phone: _____

Emergency contact: _____ Phone: _____

Do you have insurance coverage for orthodontic treatment? Yes ❑ No ❑

If yes, name of employer on policy: _____ Group #: _____

Primary policy holder's name: _____ Date of Birth: _____

Insurance company name: _____ ID #: _____

Your dentist _____ Last checkup date _____
(first and last name please)

How did you hear about us? _____

What is your primary concern? Why are you seeing us today, in your own words?

_____

_____

_____
*Initials*

**DENTAL HISTORY**: Do you now have or ever had? Check all that apply

- ❑ Braces
- ❑ Nightguard
- ❑ TMJ splint
- ❑ Wisdom teeth extracted
- ❑ Supernumerary ("extra") teeth. If so, have they been removed? Yes ❑ No ❑
- ❑ Congenitally missing teeth
- ❑ Pain in jaws
- ❑ Difficulty in chewing or jaw opening
- ❑ Jaws "noisy" when you open and close
- ❑ Jaws stick or lock
- ❑ Tooth grinding or jaw clenching
- ❑ Food impaction/stuck between teeth
- ❑ Have you ever been treated for "TMD" or "TMJ"
- ❑ Frequent canker sores or cold sores
- ❑ Abnormal swallowing habit (tongue thrusting)
- ❑ Ever had a prior orthodontic examination
- ❑ Thumb, finger, or sucking habit? Until what age_____?
- ❑ History of speech problems
- ❑ Mouth breathing habit, snoring or difficulty breathing
- ❑ Periodontal/"gum" problems
- ❑ Had periodontal (gum) treatment
- ❑ Any teeth irritating cheek, lip, tongue or palate
- ❑ Aware of loose, broken or missing restorations (fillings)
- ❑ Any pain or soreness in the muscles of the face, jaws or around the ears?
- ❑ Aware or concerned about under or over developed jaw
- ❑ Any relative with similar tooth or jaw relationships (severe overjet, overbite, underbite...)
- ❑ Had any serious trouble associated with any previous dental treatment. Explain: _____

_____

❑ Under another dentist's or specialist's care? Name/reason:_____

❑ Other issues we should know about_____

How often do you brush:_____ Floss _____

**FAMILY MEDICAL HISTORY**: Do you, your parents or siblings have or ever had any of the following:

❑ Arthritis ❑ Severe Allergies ❑ Jaw size imbalance ❑ Unusual dental problems

If yes to any of these, please explain_____

_____

Do you chew or smoke tobacco? Yes ❑ No ❑ Which (smoke or chew)? _____

If you have quit, when?_____

Do you have an allergy-like sensitivity to alcohol?_____ To what extent:_____

_____
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**MEDICAL HISTORY**: Do you now have or ever had? Check all that apply

- ❑ Birth defects or hereditary problems
- ❑ Rheumatoid or arthritic conditions
- ❑ Bone disease or osteoporosis
- ❑ Nutritional deficiencies
- ❑ Stroke(s)
- ❑ Stomach ulcer or hyperacidity
- ❑ Hepatitis, jaundice or liver problem
- ❑ Cysts or polyps
- ❑ Vision, hearing, tasting or speech difficulties
- ❑ Tuberculosis
- ❑ High or low blood pressure
- ❑ Frequent headaches, cold or sore throats
- ❑ Bone fractures, any major accidents
- ❑ Endocrine or thyroid problems
- ❑ Diabetes
- ❑ Cancer, tumor, radiation treatment or chemotherapy
- ❑ Skin disorder(s)
- ❑ Problems of the immune system
- ❑ Mental health disturbance or depression
- ❑ Rheumatic fever
- ❑ History of eating disorder (anorexia, bulimia)
- ❑ Nasopharyngeal conditions
- ❑ Oral herpes
- ❑ Eye, ear, nose or throat conditions
- ❑ Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)
- ❑ Fainting spells, seizures, epilepsy or neurological problem

❑ Asthma. How often do you use an inhaler for attacks?_____

❑ Other: _____

❑ Other: _____

Women: are you pregnant? Yes ❑ No ❑ Are you anticipating becoming pregnant? Yes ❑ No ❑

Have you ever taken bisphosphonates (for osteoporosis or bone density loss)? Yes ❑ No ❑

Operations? describe_____

Hospitalized? for_____

Please list all medications regularly taken; both prescription & over-the-counter drugs:

| What ? | Why ? |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

List anything you are allergic to (penicillin, latex, etc.) _____

_____

Have you ever had a significant blow to the face, head or a whiplash injury? Yes ❑ No ❑

Date?_____ What part of the head?_____ Were any teeth involved? Yes ❑ No ❑

_____
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Has there been a recent change in your lifestyle such as in marital status, childbirth, change of employment, death in the family, or other stressful condition? Is there any illness or problem not listed that we should know about? Is there anything about your teeth, face, nose, or jaws that you would like to change? Please feel free to tell us anything else you feel we should know that may be related to your orthodontic, jaw, tooth, and/or jaw joint problem.

_____

_____

_____

_____

_____

_____

_____

Thank you for choosing us!
We're looking forward to meeting you!

Dr. Matthew C. Biermann
Orthodontics and Dentofacial Orthopedics

I, by my signature below, give permission for release of any pertinent information about my health that may be necessary for proper diagnosis and treatment of information regarding treatment to my dentist or other health professional. You have my permission to use clinical diagnostic materials such as x-rays, study models, photographic images, etc., in consultation with others regarding my treatment.

Signed: X_____Date Signed : _____
Patient

Signed: X_____Date Signed : _____
Doctor

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