KUPPERS ORTHODONTICS

Live Your Life Smiling®

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Adult Medical History Form

The following information is requested to enable us to provide you an accurate evaluation of your orthodontic condition. This information, which is important for our records and your health, is **confidential.**

Patient's Name: _____

Birthdate (M/D/Yr): _____ Gender: ☐ M ☐ F

Address: _____ Postal Code: _____

Home Tel: _____ Work Tel: _____ Cell: _____

Email: _____

Best way to reach you **during business hours:** ☐ Home ☐ Work ☐ Cell ☐ Email

Person financially responsible: ☐ Self ☐ Other (If other, please list name, address and tel # below)

_____

Do you have orthodontic insurance coverage? ☐ N ☐ Y

Have we treated any other family member? ☐ N ☐ Y **Please list names:** _____

Patient's Dentist: _____ Patient's Physician: _____

Whom may we thank for referring you to our practice? _____

What is your reason for arranging an orthodontic consultation? _____

Have you had previous orthodontic treatment? ☐ N ☐ Y
If yes, when and what type of treatment? _____

Have you had any injuries to the jaws, face or teeth? ☐ N ☐ Y
If yes, please specify: _____

Have you had teeth removed? ☐ N ☐ Y
If yes, please specify: _____

Do you experience any of the following: Difficulty breathing through nose? ☐ N ☐ Y

Unusual number of headaches? ☐ N ☐ Y

Jaws click, crack or lock? ☐ N ☐ Y

Grind or clench your teeth? ☐ N ☐ Y

Do you smoke? ☐ N ☐ Y **If yes,** how much? _____

Females: Are you pregnant or suspect you may be? ☐ N ☐ Y

Do you have any of the following conditions? **(Please indicate)**

Asthma	Kidney / Liver problem	Epilepsy / Seizures
Bleeding disorder	Heart disorder / Murmur	Cold Sores
Hepatitis	HIV / AIDS	Diabetes
Fainting or Dizzy Spells	High / Low Blood Pressure	Anemia
Arthritis	Cancer	Latex Allergy

Other Conditions:

_____
_____
_____

Are you currently under a physician's care? ☐ N ☐ Y **Please specify:** _____

Are you taking any medications? ☐ N ☐ Y **Please specify:** _____

Any known allergies or drug reactions? ☐ N ☐ Y **Please specify:** _____

Any Additional Comments?

_____
_____
_____
_____
_____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by Dr. Kuppers and his team to help determine appropriate orthodontic treatment. If there are changes in my medical status, I will inform Dr. Kuppers or his team.

Date: _____ Signature: _____