# Cavanaugh & Nondorf Orthodontics, P.C.
## Medical/Dental History Form for Adult

Patients Last Name:_____First:_____M.I._____ Date:_____
Date of Birth: _____ Age:_____ Sex:_____ Home Phone:_____
Patients Address:_____City:_____State:_____Zip:_____
Social Security # of Responsible Parties:_____ Phone #:_____
His/Her Address:_____City:_____State:_____Zip:_____
Patient is: Single:_____ Married:_____Widowed:_____ Separated: _____ Divorced_____
Name of Patients Dentist: _____Referred By:_____
Musical Instrument Played:_____
Sports, Hobbies & Avocations:_____
Occupation:_____Employer:_____ Work Phone:_____
In case we cannot reach you: Person to contact_____ Phone #_____

## Medical History

Health Quality: □ Good □ Fair □ Poor Allergies: □ Food □ Drug □ Hay fever □ Asthma □ Other

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

| | | | | | |
|---|---|---|---|---|---|
| Hepatitis | Diabetes | Kidney Problems | Sinus Problems | Immune Disorder | Lip or Tongue Biting |
| Frequent Headaches | Heart Disease | Bleeding Gums | Arthritis | Speech Impairment | Nail Biting |
| Cerebral Palsy | Epilepsy | Liver Disease | Convulsions/Seizures | Tonsils/Adenoids | Tuberculosis |
| Rheumatic Fever | Excessive Bleeding | Cold Sores/Fever Blisters | Throat Infections | Mouth Breathing | Hemophilia |
| Frequent Colds | Thyroid Problems | Dizziness or Fainting | Grinding of Teeth | Thumb/Finger Sucking | Difficult Breathing |
| Latex Sensitivity | Artificial Joints | AIDS/HIV | Radiation Therapy | Chemotherapy | Other |

Please Explain:_____

_____

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? _____
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 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