CONFIDENTIAL

Lafayette Family Orthodontics
BRIAN C. LEYPOLDT, DDS, MSD
Your Smile Is Our Specialty

Medical / Dental History Form – Over 18

PATIENT

Today's Date: ____/____/____

Last Name: _____ First Name: _____ Middle Initial: _____

Prefers to be called: _____ Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female

Address: _____City:_____Zip Code:_____

Cell Phone: ( )_____-_____ Cell Carrier: _____ Work Phone: ( )_____-_____

Email Address: _____@_____.com

Hobbies and Activities: _____

DENTIST

Have you had a dental check-up within the last 6 months? ☐ Yes; ☐ No

Dentist: _____ Date of Last Visit: _____/_____/_____

Other dentists/dental specialists being seen? _____

DENTAL INSURANCE

Primary Policy holder's full name: _____ Date of Birth: ____/____/____

Social Security #: _____-_____-_____ Relationship to Patient: _____

Employer:_____ Address: _____

Insurance Company Name: _____Group #: _____ ID#:_____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

Secondary Policy holder's full name: _____ Date of Birth: ____/____/____

Social Security #: _____-_____-_____ Relationship to Patient: _____

Employer:_____ Address: _____

Insurance Company Name: _____Group #: _____ ID#:_____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

PATIENT / FAMILY HEALTH INFORMATION

Please list any medication, nutritional supplements, herbal medications, or non-prescription medicines, including fluoride supplements that you take.

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Do you require antibiotic pre-medication before any dental procedures? _____

Do you chew, smoke, or vape any tobacco product? _____

Did your mother and/or father ever have orthodontic treatment? _____

Did your mother and/or father require jaw surgery as part of orthodontic treatment: _____

For the following question, please mark yes, no, or don't know (DK). Please mark each question individually, do NOT draw a line through all answers. Thank you.

Medical History
Now, or in the past, have you had:

Yes	No	DK	
☐	☐	☐	Birth defects or hereditary problems?
☐	☐	☐	Bone fractures of major injuries?
☐	☐	☐	Any injuries to face, head, neck?
☐	☐	☐	Arthritis or joint problems?
☐	☐	☐	Seizures, fainting spells, neurological problems?
☐	☐	☐	Mental health disturbances and/or depression?
☐	☐	☐	Frequent headaches or migraines?
☐	☐	☐	Heart defects, heart murmur, rheumatic heart disease?
☐	☐	☐	Do you frequently breath through your mouth?
☐	☐	☐	Have you ever taken intravenous bisphosphanates for bone disorders or cancer?
☐	☐	☐	Have you ever taken oral bisphosphanates for bone disorders?
☐	☐	☐	Surgeries: _____ _____

Are you allergic to or suffered reactions to any of the following?

Yes	No	DK	
☐	☐	☐	Latex (gloves, balloons)
☐	☐	☐	Aspirin
☐	☐	☐	Ibuprofen (Motrin, Advil)
☐	☐	☐	Metals (jewelry, clothing snaps)
☐	☐	☐	Acrylics
☐	☐	☐	Other substances: _____

Dental History
Now, or in the past, have you had:

Yes	No	DK	
☐	☐	☐	Permanent teeth removed?
☐	☐	☐	Congenitally missing teeth?
☐	☐	☐	Presence of extra (supernumerary) teeth?
☐	☐	☐	Chipped or injured permanent teeth?
☐	☐	☐	Any sensitive or sore teeth?
☐	☐	☐	Any lost or broken fillings?
☐	☐	☐	Jaw fractures, cysts, or infections?
☐	☐	☐	Any teeth treated with root canals or pulpotomies?
☐	☐	☐	Placement of Dental Implants?
☐	☐	☐	Frequent canker sores or cold sores?
☐	☐	☐	History or speech problems or speech therapy?
☐	☐	☐	Difficulty breathing through nose?
☐	☐	☐	Mouth breathing habit or snoring at night?
☐	☐	☐	Frequent oral habits (fingers, thumbs, pens, etc.)
☐	☐	☐	Teeth causing irritation to lip, cheek, or gums?
☐	☐	☐	Tooth grinding or clenching?
☐	☐	☐	Clicking, locking of jaw joints?
☐	☐	☐	Soreness in jaw or face muscles?
☐	☐	☐	Have you been treated for "TMJ" or "TMD" problems?
☐	☐	☐	Any trouble associated with prior dental treatment?
☐	☐	☐	Have you ever been diagnosed with periodontal (gum) disease?

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature: _____ Date: _____/_____/_____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature: _____ Date: _____/_____/_____

MEDICAL HISTORY UPDATES OR CHANGES

Changes: _____

Signature: _____ Date: _____/_____/_____

Staff Signature: _____ Date: _____/_____/_____