

CONFIDENTIAL

Medical Dental History Form for Patients Under Age 18

PATIENT

Date _____
Patient's Last name _____ First name _____ Middle initial _____
Prefers To Be Called _____ Hobbies, activities _____
Birth date _____ Sex: Male Female
Social Security # _____ - _____ - _____
School _____ Grade _____ E-mail address(es) _____
Home address _____ City, State, Zip code _____
Home phone (_____) _____ - _____ Cell phone (_____) _____ - _____

PARENT/GUARDIAN

Custodial parent(s) name (s) _____
Patient lives with (*check all that apply*) mother father stepmother stepfather grandparent(s)
 other If other, what is the relationship? _____
Father's full name _____ Title Mr. Dr. Other _____
Occupation _____ Email address _____
Address (*if different*) _____
Cell Phone (*if different*): (_____) _____ - _____ Home phone (_____) _____ - _____
Work phone (_____) _____ - _____

Mother's full name _____ Title Mrs. Ms. Dr. Other _____
Occupation _____ Email address _____
Address (*if different*) _____
Cell Phone (*if different*): (_____) _____ - _____ Home phone (_____) _____ - _____
Work phone (_____) _____ - _____

DENTIST

Patient's Dentist _____ Address, City, State _____
Last seen _____ Reason _____ Next appointment _____

Other dentists/dental specialists now being seen: Name _____ City, State _____

Reason _____

GENERAL INFORMATION

What concerns you about your child's teeth? _____

What concerns your child about his/her teeth? _____

How does your child feel about orthodontic treatment? _____

Who suggested that your child might need orthodontic treatment? _____

Why did you select our office? _____

Describe any previous orthodontic treatment or consultations. _____

Does your child play a musical instrument? _____

Brother/sister name _____ age _____ had orthodontic treatment? Yes No If yes, where? _____

Brother/sister name _____ age _____ had orthodontic treatment? Yes No If yes, where? _____

Brother/sister name _____ age _____ had orthodontic treatment? Yes No If yes, where? _____

Brother/sister name _____ age _____ had orthodontic treatment? Yes No If yes, where? _____

Have any other family members been treated in this office? Please name them. _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____

Address (if different from page 1) _____ City, State, Zip _____

Cell phone (_____) _____ - _____ Home phone (_____) _____ - _____

E-mail address(es) _____

Social Security # _____ - _____ - _____ Employer _____

Who will be responsible for bringing the patient to orthodontic appointments? _____

DENTAL INSURANCE

Primary policy holder's full name _____ Birth date _____

Social Security # _____ - _____ - _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID # _____

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

Secondary policy holder's full name _____ Birth date _____

Social Security # _____ - _____ - _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID # _____

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

MEDICAL INSURANCE

Policy holder's full name _____

Insurance company _____

PHYSICIAN

Patient's Physician _____ City, State _____

Last seen _____ Reason _____ Next appointment _____ Most recent physical exam _____

Other physicians/health care providers being seen now:

Name _____ City, State _____ Reason _____

Name _____ City, State _____ Reason _____

Your answers are for office records only and are confidential. A thorough medical history is essential to a complete orthodontic evaluation. For the following questions, mark yes, no, or don't know/understand (dk/u).

PATIENT HEALTH INFORMATION

Do you take antibiotic pre-medication before any dental procedures? Yes No

Does the patient currently have (or ever had) a substance abuse problem? _____

Do you think that any of your child's activities affect his/her face, teeth or jaws? How? _____

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that your child takes.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Does your child chew or smoke tobacco? _____

Have you noticed any unusual changes in your child's face or jaws? _____

Any other physical problems? _____

MEDICAL HISTORY

Now or in the past, has your child had:

yes no dk/u Emotional, sensory or developmental issues?

yes no dk/u Birth defects or hereditary problems?

yes no dk/u Bone fractures, or major injuries?

yes no dk/u Any injuries to face, head, neck?

yes no dk/u Arthritis or joint problems?

yes no dk/u Cancer, tumor, radiation treatment or chemotherapy?

yes no dk/u Endocrine or thyroid problems?

yes no dk/u Diabetes or low sugar?

yes no dk/u Kidney problems?

yes no dk/u Immune system problems?

yes no dk/u History of osteoporosis?

yes no dk/u Gonorrhea, syphilis, herpes, sexually transmitted diseases?

yes no dk/u AIDS or HIV positive?

yes no dk/u Hepatitis, jaundice or other liver problems?

yes no dk/u Polio, mononucleosis, tuberculosis, pneumonia?

yes no dk/u Seizures, fainting spells, neurologic problem?

yes no dk/u Mental health disturbance or depression?

yes no dk/u History of eating disorder (anorexia, bulimia)?

yes no dk/u Frequent headaches or migraines?

yes no dk/u High or low blood pressure?

yes no dk/u Excessive bleeding or bruising tendency, anemia?

yes no dk/u Chest pain, shortness of breath, tire easily, swollen ankles?

yes no dk/u Heart defects, heart murmur, rheumatic heart disease?

yes no dk/u Angina, arteriosclerosis, stroke or heart attack?

- yes no dk/u Skin disorder (other than common acne)?
- yes no dk/u Does your child eat a well-balanced diet?
- yes no dk/u Vision, hearing, or speech problems?
- yes no dk/u Frequent ear infections, colds, throat infections?
- yes no dk/u Asthma, sinus problems, hayfever?
- yes no dk/u Tonsil or adenoids removed?
- yes no dk/u Does your child frequently breathe through his/her mouth?
- yes no dk/u Has your child ever taken intravenous medication for bone disorders or cancer such as bisphosphonates such as Zometa (zoledronic acid), Aredia (pamidronate) or Didronel (etidronate)?
- yes no dk/u Has your child ever taken oral medication for bone disorders such as bisphosphonates such as Fosamax (alendronate), Actonel (risedronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) ?

- yes no dk/u History of speech problems or speech therapy?
- yes no dk/u Difficulty breathing through nose?
- yes no dk/u Mouth breathing habit or snoring at night?
- yes no dk/u History of speech problems?
- yes no dk/u Frequent habit of thumb/finger sucking?
Current ___ Yes ___ No Age stopped _____
- yes no dk/u Frequent habit of tongue thrust?
Current ___ Yes ___ No Age stopped _____
- yes no dk/u Frequent habit of fingernail biting?
Current ___ Yes ___ No Age stopped _____
- yes no dk/u Frequent habit of lip sucking?
Current ___ Yes ___ No Age stopped _____
- yes no dk/u Teeth causing irritation to lip, cheek or gums?
- yes no dk/u Tooth grinding or clenching?
- yes no dk/u Clicking, locking in jaw joints?
- yes no dk/u Soreness in jaw muscles or face muscles?
- yes no dk/u Has your child been treated for "TMJ" or "TMD" problems?
- yes no dk/u Any broken or missing fillings?
- yes no dk/u Any serious trouble associated with previous dental treatment?
- yes no dk/u Has your child ever been diagnosed with gum disease or pyorrhea?

MEDICAL HISTORY continued

Has your child had allergies or reactions to any of the following?

- yes no dk/u Latex (gloves, balloons)
- yes no dk/u Metals (jewelry, clothing snaps)
- yes no dk/u Acrylics
- yes no dk/u Local anesthetics (novocaine, lidocaine, xylocaine)
- yes no dk/u Aspirin
- yes no dk/u Ibuprofen (Motrin, Advil)
- yes no dk/u Penicillin
- yes no dk/u Other antibiotics
- yes no dk/u Plant pollens
- yes no dk/u Animals
- yes no dk/u Foods
- yes no dk/u Other substances _____

DENTAL HISTORY

Now or in the past, has the patient had:

- yes no dk/u Erupting teeth very early or very late?
- yes no dk/u Primary (baby) teeth removed that were not loose?
- yes no dk/u Permanent or extra (supernumerary) teeth removed?
- yes no dk/u Supernumerary (extra) or congenitally missing teeth?
- yes no dk/u Chipped or injured primary or permanent teeth?
- yes no dk/u Any sensitive or sore teeth?
- yes no dk/u Any lost or broken fillings?
- yes no dk/u Jaw fractures, cysts, infections?
- yes no dk/u Any teeth treated with root canals or pulpotomies?
- yes no dk/u Frequent canker sores or cold sores?

How often does your child brush? _____
Floss? _____

FAMILY MEDICAL HISTORY

Have the parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders _____

Diabetes _____

Arthritis _____

Severe allergies _____

Unusual dental problems _____

Jaw size imbalance _____

Other family medical conditions? _____

RELEASE AND WAIVER

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

Parent/Guardian 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 child's medical or dental health.

Parent/Guardian Signature _____

Date _____

MEDICAL HISTORY UPDATES

Changes _____

Parent/Guardian Signature _____

Date _____

Dental Staff Signature _____

Date _____

Changes _____

Parent/Guardian Signature _____

Date _____

Dental Staff Signature _____

Date _____

Changes _____

Parent/Guardian Signature _____

Date _____

Dental Staff Signature _____

Date _____