

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) ? |

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?
☐ 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?

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 _____