

Medical Dental History Form for Patients Under Age 18

PATIENT

Date			
			anan-tiwa
			Middle initial
	Sex Male		
	Grade		
Home phone ()	Cell phone ()	·
PARENT/GUAR	DIAN		
Custodial parent(s) nan			
Patient lives with (check	all that apply) Mother [☐ Father ☐ Stepmother ☐ Stepfather	Grandparent(s) Other
Father's full name		Title	e:
Occupation		Email address	
	()		Work phone ()
Mother's full name		Title:	Other
Occupation		Email address	
Address (// different)			
Home Phone (If different	()	Cell phone ()	Work phone ()
DENTIST			
Patient's Dentist		Address, City, State	
Last seen			Next appointment
			City, State
	pocialises from being seen. I		

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	ΠNo	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 then page 1)		Cř	h: Steta	7in	
Home phone () C	ell phone (s(es)
Social Security #		Employer		oourco.	400/
Who will be responsible for bringing the patient t	o orthodor	tic appointments?			
DENTAL INSURANCE					
Primary policy holder's full name					Birth date
		Relationship to patient			
Address and phone (if not listed above)					
Employer		Address			
Insurance company		Group #		_ ID/	
Does this policy have orthodontic benefits?	es 🗆 No	☐ Don't Know			
Secondary policy holder's full name					
					Birth date
Address and phone (if not listed above)		Relationship to patient			
Employer		4.44			
nsurance company		Address			
Does this policy have orthodontic benefits?	es 🗆 No	Group #	_ 10# _		
	D 140	LI DON'T NAME			
MEDICAL INSURANCE					
folicy holder's full name					
nsurance Company					
PHYSICIAN					
atient's Physician		City, State			
ast seen					Next appointment
lost recent physical exam		1100001			Ivext appointment
ther physicians/health care providers being seen	now:				
ame		City, State			
eason					
ame		City, State			
nason					
					History Form - Child - 5/13

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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, please mark yes, no, or don't know/understand (dk/u).

No	MED www.	r in	CAL HISTORY the past, has your child had:	Has your child had allergies or reactions to any of the following?
]] [☐ Birth defects or hereditary problems?	☐ ☐ Local anesthetics (novocaine, lidocaine, xyfocaine)
			Bone fractures or major injuries?	Latex (gloves, balloons)
			Any injuries to face, head, neck?	□ □ Aspirin
			Arthritis or joint problems?	☐ ☐ Ibuprofen (Motrin, Advil)
			Cancer, tumor, radiation treatment or chemotherapy?	Penicillin
		10	Endocrine or thyroid problems?	□ □ Other antibiotics
			Diabetes or low sugar?	☐ ☐ Metals (jewelry, clothing snaps)
			Nidney problems?	□ □ Acrylics
			Immune system problems?	□ □ Plant pollens
			History of osteoporosis?	□ □ Animals
			Gonorrhea, syphilis, herpes, sexually transmitted diseases?	□ □ Foods
			AIDS or HIV positive?	Other substances
			Hepatitis, jaundice, or other liver problems?	
			Polio, mononucleosis, tuberculosis, pneumonia?	DENTAL HISTORY
			Seizures, fainting spells, neurologic problems?	Now or in the past, has your child had:
			Mental health disturbance or depression?	□ □ Erupting teeth very early or very late?
			History of eating disorder (anorexia, bulimia)?	□ □ Primary (baby) teeth removed that were not loose?
			Frequent headaches or migraines?	□ □ Permanent or extra (supernumerary) teeth removed?
			High or low blood pressure?	□ □ Supernumerary (extra) or congenitally missing teeth?
			Excessive bleeding or bruising, anemia?	☐ ☐ Chipped or injured primary or permanent teeth?
			Chest pain, shortness of breath, tire easily, swollen ankles?	□ □ Any sensitive or sore teeth?
			Heart defects, heart murmur, rheumatic heart disease?	□ □ Any lost or broken fillings?
			Angina, arteriosclerosis, stroke or heart attack?	□ □ Jaw fractures, cysts, infections?
			Skin disorder (other than common acne)?	☐ ☐ Any teeth treated with root canals or pulpotomies?
			Does your child eat a well-balanced diet?	☐ ☐ Frequent canker sores or cold sores?
			Vision, hearing, or speech problems?	☐ ☐ History of speech problems or speech therapy?
			Frequent ear infections, colds, throat infections?	Difficulty breathing through nose?
			Asthma, sinus problems, hayfever?	☐ ☐ Mouth breathing habit or snoring at night?
			Tonsil or adenoid condition?	☐ ☐ History of speech problems?
			Does your child frequently breathe through his/her mouth?	☐ ☐ Prequent oral habits (sucking finger, chewing pen, etc)?
] [Has your child ever taken intravenous hisphosphosphosphosphosphosphosphosphospho	□ □ Teeth causing initiation to lip, cheek or gums?
			such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?	□ □ Tooth grinding or clenching?
0	0		Has your child ever taken oral hisphosphoretee such as	□ □ Clicking, locking in jaw joints?
				□ □ Soreness in jaw muscles or face muscles?
		1	ibandronate), Sixelid (tiludronate) or Didronel (etidronate) for bone disorders?	☐ ☐ Has your child been treated for "TMU" or "TMD" problems?
				☐ ☐ Any broken or missing fillings?
				□ □ Any serious trouble associated with previous dental treatment?
				☐ ☐ Has your child ever been diagnosed with gum disease or pyorhea?

PATIENT HEALTH INFORMATION

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

List any medication, nutritional supplements, herbi	I medications or non-prescription medicines, including fluoride supplements that your child	d takes
Medication	Taken for	
Medication	Taken for	
Medication	Taken for	
Does your child take antibiotic pre-medication bef	ore any dental procedures?	
loes your child have (or ever had) a substance all	use problem?	
Does your child chew or smoke tobacco?		
lave you noticed any unusual changes in your ch	ld's face or jaws?	
Any other physical problems?		_
FAMILY MEDICAL HISTORY		
Have the parents or siblings ever had any of the f	ollowing health problems? If so, please explain.	
Bleeding disorders		_
Arthritis		
Unusual dental problems	Jaw size imbalance	_
Other family medical conditions?		-
How often does your child brush?	Floss?	
RELEASE AND WAIVER		
l authorize release of any information regarding	my chilid's orthodontic treatment to my dental and/or medical insurance company.	
authorize release of any information regarding		
authorize release of any information regarding Parent/Guardian Signature	Date	у егго
Parent/Guardian Signature	Date Date Them. I will not hold my orthodontist or any member of his/her staff responsible for an of this form. I will notify my orthodontist of any changes in my child's medical or denta	ny erro I bealt
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