



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

Medical / Dental History Form

PATIENT

Today's Date: ___/___/___

Patient's Last Name: _____ First Name: _____ Middle Initial: _____

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

Hobbies and Activities: _____

School: _____ Grade Level: _____

Siblings (Name and Age): _____

PARENT/GUARDIAN

Parent(s)/Guardian(s) Full Name(s): _____

Email Address: _____@_____.com

Address: _____

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

DENTIST

Patient's Dentist: _____ Date of Last Visit: ___/___/___

Reason for last visit: _____

Other dentists/dental specialists now being seen? _____

Reason: _____

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 your child takes.

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Does your child require antibiotic pre-medication before any dental procedures? _____

Does your child chew, smoke, or vape any tobacco product? _____

Has the patients' mother and/or father ever had orthodontic treatment? _____

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

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

Medical History

Now, or in the past, has your child had:

Yes No DK/U

- 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?
- Does your child frequently breath through his/her mouth?
- Has your child ever taken intravenous bisphosphanates for bone disorders or cancer?
- Has your child ever taken oral bisphosphanates for bone disorders?

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

Yes No DK/U

- Latex (gloves, balloons)
- Aspirin
- Ibuprofen (Motrin, Advil)
- Metals (jewelry, clothing snaps)
- Acrylics
- Other substances: _____

Dental History

Now, or in the past, has your child had:

Yes No DK/U

- Erupting teeth very early or very late?
- Primary (baby) teeth removed that were not loose?
- Permanent teeth removed?
- Congenitally missing teeth?
- Presence of extra (supernumerary) teeth?
- Chipped or injured primary or 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?
- 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 cause irritation to lip, cheek, or gums?
- Tooth grinding or clenching?
- Clicking, locking of jaw joints?
- Soreness in jaw or face muscles?
- Has your child been treated for "TMJ" or "TMD" problems?
- Any trouble associated with prior dental treatment?
- Has your child ever been diagnosed with periodontal (gum) disease?

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 OR CHANGES

Changes: _____

Parent/Guardian Signature: _____ Date: ____/____/____

Staff Signature: _____ Date: ____/____/____