My Life. My Smile. My Orthodontist.

CONFIDENTIAL

Medical Dental History Form
for Patients Under Age 18

Date:

Patient

Patient's last name: ____________ First name: ____________ Middle Initial ______

Prefers to be called: ____________ Hobbies/interest/activites: ____________

Birth date: ____________ Age ______ Sex Male ◯ Female ◯ SSN # ____________

Home address ____________ City, State, Zip Code ____________

Home phone: ____________ Cell phone: ____________ Work phone: ____________

School: ____________ Grade: ______ Email Address(es) : ____________

Parent/Guardian

Custodial parent(s) name(s) ____________

Patient lives with (check all that apply) ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandparent(s) ☐ Other ______

Father's full name: ____________ Title: ☐ Mr ☐ Dr ☐ Other

Occupation: ____________ Email address: ____________

Address (if different) ____________

Home phone: ( ) - ______ Cell phone: ( ) - ______ Work phone: ( ) - ______

Mother's full name: ____________ Title: ☐ Mr ☐ Dr ☐ Other

Occupation: ____________ Email address: ____________

Address (if different) ____________

Home phone: ( ) - ______ Cell phone: ( ) - ______ Work phone: ( ) - ______

Financial Responsibility

Who is financially responsible for this account? ____________

Address(if different than page ____________ City, State, Zip Code ____________

1) ______________________ ______________________

Home phone: ______________ Cell phone: ______________ Email address: ______________

Social Security #: ______________ Employer: ______________________

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

Dentist

Patient's Dentist: ______________ Address, City, State ______________________

Last Seen ____________ Reason ______________ Next Appointment ____________

Other dentist/dental specialist now being seen: Name: ______________ City, State ______________

Reason: ____

Physician

Patient's Physician: ______________ City, State ______________________

Last Seen ____________ Reason ______________ Next Appointment ____________

Other physician/health care providerb: Name: ______________ City, State ______________

Reason: ____

Other physician/health care providerb: 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 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 treatemtn? ☐ Yes ☐ No If yes, where?

Brother/sister name ________________ age _____ had orthodontci treatment? ☐ Yes ☐ No If yes, where?

Have any other family members been treated in this office? Please name them: ______________________________

Dental Insurance

Primary policy holder's full name:

______________________________ Birth date: __________

Social Security # ______________________ Relationship to patient: __________________

Address (if different than page 1) ____________________ City, State, Zip Code __________________

Home phone: ( ) - ______________ Cell phone: ( ) - ______________ Work phone: ( ) - ______________

Employer: ______________________ Address: ______________________

Insurance Company: ____________________ Group #: __________ ID#: ______________

Does this policy have orthodontic benefits? ◯ Yes ◯ No ◯ Don't Know - Please find out my benefit for me.

Secondary policy holder's full name:

______________________________ Birth date: __________

Social Security # ______________________ Relationship to patient: __________________

Address (if different than page 1) ____________________ City, State, Zip Code __________________

Home phone: ( ) - ______________ Cell phone: ( ) - ______________ Work phone: ( ) - ______________

Employer: ______________________ Address: ______________________

Insurance Company: ____________________ Group #: __________ ID#: ______________

Does this policy have orthodontic benefits? ◯ Yes ◯ No ◯ Don't Know - Please find out my benefit for me.

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).

Medical History

Yes	No	DK/U	Now or in the past, have you had:
			Birth defects or hereditary problems?
			Bone Fractures or major injuries?
			Any injuries to face, head, neck?
			Arthritis or joint problems?
			Endocrine or thyroid problems?
			Diabetes or low sugar?
			Kidney problems?
			Cancer, tumor, radiation treatment or chemotherapy?
			Immune system problems?
			History of osteoporosis?
			Gonorrhea, syphilis, herpes, sexually transmitted diseases?
			AIDS or HIV positive?
			Hepatitis, jaundice, or other liver problems?
			Polio, mononucleosis, tuberculosis, pneumonia?
			Seizures, fainting spells, neurologic problems?
			Mental health disturbance or depression?
			Vision, hearing, or speech problems?
			History of eating disorder (anorexia, bulimia)?
			Frequent headaches or migraines?
			High or low blood pressure?
			Excessive bleeding or bruising, anemia?
			Chest pain, shortness of breath, tire easlily, swollen ankles?
			Heart defects, heart murmur, rheumatic heart disease?
			Angina, arteriosclerosis, stroke, or heart attack?
			Skin disorder (other than common acne)?
			Do your child eat a well-balanced diet?
			Frequent ear infections, colds, throat infections?
			Asthma, sinus problems, hayfever?
			Tonsil or adenoid condition?
			Does your child frequently breathe through his/her mouth?
			Has your child ever taken intravenous bisphosphonates such as Zometa (zolendronic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?
			Has your child ever taken oral bisphosphonates such as Fosamax (alendronate), Actone (ridendronate), Boniva (ibandronated), Skelid (tiludronte), or Didronel (etidronate) for bone disorders?

Yes	No	DK/U	Have you had allergies or reactions to any of the following?
			Local anesthetics (novocaine, lidocaine)
			Latex (gloves, balloons)
			Aspirin
			Metals (jewelry, closthing snaps)
			Penicillin
			Other antibiotics
			Ibuprofen (Motrin, Advil)
			Acrylics
			Plant pollens
			Animals
			Foods
			Other substances

Dental History

Yes	No	DK/U	Now or in the past, have you had:
			Erupting teeth very early or very late?
			Primary (baby) teeth removed that were not loose?
			Permanent or extra (supernumerary) teeth removed?
			Supernumerary (extra) or congenitally missing teeth?
			Chipped or injured primarhy or permanent teeth?
			Any sensitive or sore teeth?
			Any lost or broken fillings?
			Jaw fractures, cysts, infections?
			Any teeth treated with root canals or pulpotomies?
			Frequent canker sores or cold sores?
			History of speech problems or speech therapy?
			Difficulty breathing through nose?
			Mouth breathing habit or snoring at night?
			Frequent oral habits (sucking finger, chewing lip, etc)?
			Teeth causing irritation to lip, cheek, or gums?
			Tooth grinding or clenchihng
			Clicking, locking in jaw joints
			Soreness in jaw muscles or face muscles?
			Hase your child been treated for "TMJ" or "TMD" problems?
			Any serious trouble associated with previous dental treatments?
			Has your child ever been diagnosed with gum disease?
			Has your child ever had an orthodontic consultation before?
			Has your child ever had previous orthodontic treatment?
If so when?			

Patient Health Information

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 take antibiotic pre-medication before any dental procedures? ______________

Does your child have (or have you ever had) a substance abuse problem? ______________

Does your child chew or smoke tobacco? ______________________

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

Any other physical problems? ______________________

How often do your child brush? __________ How often do your child floss? __________

Family Medical History

Have your 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 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 Update or Changes

Changes: ______________________

Signature: ______________________ Date: __________

Dental Staff Signature: ______________________ Date: __________