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MEDICAL DENTAL HISTORY FORM FOR PATIENTS UNDER 18 YEARS OF AGE

--CONFIDENTIAL--

PLEASE COMPLETE THIS FORM AND BRING IT TO THE APPOINTMENT.

Date: _____

PATIENT INFORMATION

Patient's Full Name: _____ I prefer to be called: _____
 Phones: Home: _____ Cell/pager: _____ Work: _____ Gender: Male Female
 Address: _____
Street City State Zipcode
 Birth date: _____ Age: _____ S.S.N.: _____ Grade: _____ School: _____
 Musical Instruments Played: _____ Sports and/or Hobbies: _____
 No. of Brothers & Sisters: _____ Ages: _____ Family members treated here: _____

PARENT(S) OR GUARDIAN(S) & RESPONSIBLE PARTY INFORMATION – LIST EACH PERSON SEPARATELY

Name: _____ Marital Status: _____ Relationship to Patient: _____
 Address: _____
Street City State Zipcode
 Phones: Home: _____ Cell/pager: _____ Work: _____ Birth date: _____
 Employed By: _____ # Years Employed: _____ SSN: _____
 Is this person financially responsible for the patient's treatment? Yes No

Name: _____ Marital Status: _____ Relationship to Patient: _____
 Address: _____
Street City State Zipcode
 Phones: Home: _____ Cell/pager: _____ Work: _____ Birth date: _____
 Employed By: _____ # Years Employed: _____ SSN: _____
 Is this person financially responsible for the patient's treatment? Yes No

Name: _____ Marital Status: _____ Relationship to Patient: _____
 Address: _____
Street City State Zipcode
 Phones: Home: _____ Cell/pager: _____ Work: _____ Birth date: _____
 Employed By: _____ # Years Employed: _____ SSN: _____
 Is this person financially responsible for the patient's treatment? Yes No

INSURANCE INFORMATION

Insurance Coverage for Ortho Treatment? Yes No Insurance Co.: _____
 Primary Policyholder: _____ S.S.N.: _____ Group No.: _____
 Birth date: _____ Employed By: _____
 Secondary Policyholder: _____ S.S.N.: _____ Birth date: _____
 Insurance Company: _____ Group No.: _____
 Employed By: _____ Work Phone: _____

Who suggested that your child might need orthodontic treatment? _____

Why did you select our office? _____

Name of Patient's General Dentist: _____ Phone No.: _____

Address: _____
Street City State Zipcode

Date Last Seen: _____ Reason: _____

Name of Patient's Physician(s): _____ Phone No.: _____

Address: _____
Street City State Zipcode

Date Last Seen: _____ Reason: _____

For the following questions mark YES, NO, or DON'T KNOW/UNDERSTAND (DK/U). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

PATIENT PROFILE

- yes no dk/u Does patient follow directions well?
- yes no dk/u Does patient brush his/her teeth conscientiously?
- yes no dk/u Does patient have learning disabilities or need extra help with instructions?
- yes no dk/u Is patient sensitive or self-conscious about teeth?

- yes no dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arterio-sclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
- yes no dk/u Skin disorder?
- yes no dk/u Does the patient eat a well-balanced diet?
- yes no dk/u Frequent headaches, colds or sore throats?
- yes no dk/u Ear, eye, nose or throat condition?
- yes no dk/u Hay fever, asthma, sinus trouble or hives?
- yes no dk/u Tonsil or adenoid conditions?

MEDICAL PROFILE

Now or in the past, have you had:

- yes no dk/u Birth defects or hereditary problems?
- yes no dk/u Bone fractures or any major accidents?
- yes no dk/u Rheumatoid or arthritic conditions?
- yes no dk/u Endocrine or thyroid problems?
- yes no dk/u Kidney problems?
- yes no dk/u Diabetes?
- yes no dk/u Cancer, tumor, radiation treatment or chemotherapy?
- yes no dk/u Stomach ulcer or hyperacidity?
- yes no dk/u Polio, mononucleosis, tuberculosis, pneumonia?
- yes no dk/u Problems of the immune system?
- yes no dk/u HIV positive or AIDS?
- yes no dk/u Hepatitis, jaundice or liver problems?
- yes no dk/u Fainting spells, seizures, epilepsy or neurological problems?
- yes no dk/u Mental health disturbance or depression?
- yes no dk/u Vision, hearing, tasting or speech difficulties?
- yes no dk/u Loss of weight recently, poor appetite?
- yes no dk/u History of eating disorder (anorexia, bulimia)?
- yes no dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?
- yes no dk/u High or low blood pressure?
- yes no dk/u Tired easily?
- yes no dk/u Chest pain, shortness of breath or swelling ankles?

Allergies or reactions to any of the following:

- yes no dk/u Local anesthetics (Novocaine or Lidocaine)
- yes no dk/u Aspirin
- yes no dk/u Ibuprofen (Motrin, Advil)
- yes no dk/u Penicillin or other antibiotics
- yes no dk/u Sulfa drugs
- yes no dk/u Codeine or other narcotics
- yes no dk/u Metals (jewelry, clothing snaps)
- yes no dk/u Latex (gloves, balloons)
- yes no dk/u Vinyl
- yes no dk/u Acrylic
- yes no dk/u Animals
- yes no dk/u Foods (specify) _____
- yes no dk/u Other substances (specify) _____
- yes no dk/u Is the patient taking medication, nutrient supplements, herbal medications or non-prescription medicine? Please name them.

Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____

- yes no dk/u Does the patient currently have or ever had a substance abuse problem?
- yes no dk/u Does the patient chew or smoke tobacco?
- yes no dk/u Operations? Describe: _____
- yes no dk/u Hospitalized? Describe: _____

 yes no dk/u Other physical problems or symptoms?
Describe: _____

 yes no dk/u Being treated by another health care professional? For: _____

Date of most recent physical exam: _____

Are there any other medical conditions that we should be aware of?
Describe: _____

GIRLS ONLY

yes no dk/u Has the patient started menstruating? If so, when? _____

yes no dk/u Is the patient pregnant?

FAMILY MEDICAL HISTORY

Do the patient's parents or siblings have any of the following health problems? If so, explain.

Bleeding disorders: _____

Diabetes: _____

Arthritis: _____

Metabolic disturbances: _____

Severe allergies: _____

Unusual dental problems: _____

Jaw size imbalance: _____

Any other family medical conditions that we should know about?

DENTAL HISTORY

Now or in the past, has the patient had:

yes no dk/u Started teething very early or 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 Chipped or otherwise injured primary (baby) or permanent teeth?

yes no dk/u Teeth sensitive to hot or cold; teeth throb or ache?

yes no dk/u Jaw fractures, cysts or mouth infections?

yes no dk/u "Dead teeth" or root canals treated?

yes no dk/u Bleeding gums, bad taste or mouth odor?

yes no dk/u Periodontal "gum problems"?

yes no dk/u Food impaction between teeth?

yes no dk/u Thumb, finger, or sucking habit? Until what age? _____

yes no dk/u Abnormal swallowing habit (tongue thrusting)?

yes no dk/u History of speech problems?

yes no dk/u Mouth breathing habit, snoring or difficulty in breathing?

yes no dk/u Tooth grinding or jaw clenching?

yes no dk/u Any pain in jaw or ringing in the ears?

yes no dk/u Any pain or soreness in the muscles of the face or around the ears?

yes no dk/u Difficulty encountered in chewing or jaw opening?

yes no dk/u Aware of loose, broken or missing restorations (fillings)?

yes no dk/u Any teeth irritating cheek, lip, tongue or palate?

yes no dk/u Concerned about spaced, crooked or protruding teeth?

yes no dk/u Are you aware or concerned about under- or over-developed jaw?

yes no dk/u "Gum boils", frequent canker sores or cold sores?

yes no dk/u Taking any form of fluoride?

yes no dk/u Any relative with similar tooth or jaw relationships?

yes no dk/u Had periodontal (gum) treatment?

yes no dk/u Would you object to wearing orthodontic appliances (braces) should they be indicated?

yes no dk/u Any serious trouble associated with any previous dental treatment?

yes no dk/u Ever had a prior orthodontic examination or treatment?

yes no dk/u Been under another dentist's care?

Specialist: _____

Other: _____

How often does the patient brush? _____

How often does the patient floss? _____

What is your primary concern? Why are you here? _____

I have read and understand the above questions. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: _____ Date: _____
(Parent or Guardian or Responsible Party)

Signed: _____ Date: _____
(Dental Staff Member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

Signed: _____ Date: _____
(Parent or Guardian)

Signed: _____ Date: _____
(Dental Staff Member)

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