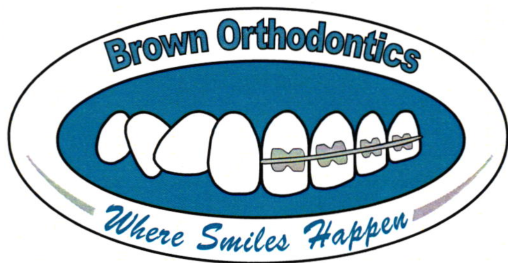


TODAY'S DATE ____________

MEDICAL DENTAL HISTORY FORM
PATIENTS UNDER 18 YEARS OF AGE

Delivering Amazing Smiles & Exceptional Service

CONFIDENTIAL

Please print in black or blue ink only

PATIENT NAME (First) ________________ (Middle) ______________ (Last) ______________(Name Called) ______________

Home Address ____

City ______________________________ State ___________ Zip _______________Home Phone No. ________________________

Birthdate _____ / _____ / _____ Age ___________ Sex M ❑ F ❑

Attends School At ____

Musical Instruments Played _________________________________ Sports and/or Hobbies ________________________________

No. of Brothers and Sisters ____Ages ________________________________

Family Members Treated Here ____

Patient's Birth Weight ______ lbs. _____ oz. Patient's Present Weight ______ lbs._____ oz. Height _______ft._____ in.

Birth Father's Height ______ft. ______in. Birth Mother's Height _______ft. _______ in.

Who suggested that your child might need orthodontic treatment? ____

Why did you select our office? ____

Name of Patient's Dentist ____ Phone No. ________________________________

Dentist Address ______________________________________ City _____________________ State _____ Zip _____________

Date Last Seen _____ / _____ / _____ Reason ____

Name of Patient's Physician ____ Phone No. ___________________________

Physician's Address ___________________________________ City ________________________State _____Zip _____________

Date Last Seen _____ / _____ / _____ Reason ____

FATHER'S NAME: Mr. ❑ Dr. ❑ Rev ❑ ____

Address: ____City _________________________State _____ Zip _____________

Home Phone No. ____________________Cell Phone No. ____________________E-Mail Address ________________________

Birth Date _____ / _____ / _____ Social Security No. (for insurance purposes only) __________ - ______ - __________

Employer ____ Occupation ____

MOTHER'S NAME: Mrs. ❑ Ms. ❑ Dr. ❑ Rev. ❑ ____

Address: ____City _________________________State _____ Zip _____________

Home Phone No. ____________________Cell Phone No. ____________________E-Mail Address ________________________

Birth Date _____ / _____ / _____ Social Security No. (for insurance purposes only) __________ - ______ - __________

Employer ____ Occupation _____________________ Marital Status ________

OTHER RESPONSIBLE PARTY NAME (if not parent)_______________ Relationship ___________

Address: _______________ City _______________ State _____ Zip ___________

Home Phone No. _______________ Cell Phone No. _______________ E-Mail Address _______________

Birth Date _____ / _____ / _____ Social Security No. (for insurance purposes only) _________ - ______ - _________

Employer _______________ Occupation _______________ Marital Status ________

INSURANCE INFORMATION

(Please supply a copy of your card to our Receptionist)

INSURANCE COVERAGE FOR DENTAL TREATMENT? YES ❑ NO ❑ INSURANCE COVERAGE FOR ORTHODONTIC TREATMENT? YES ❑ NO ❑

PRIMARY Policy Holder's Name _______________ Birthdate _____ / _____ / _____

SSN or ID NO: _______ - ______ - _______ Employed by _______________

Dental Insurance Co. Name _______________ Customer Service Phone No. _______________

Claims Address _______________ City _______________ State ______ Zip ___________

Group Name _______________ Group No. _______________

SECONDARY Policy Holder's Name _______________ Birthdate _____ / _____ / _____

SSN or ID NO: _______ - ______ - _______ Employed by _______________

Dental Insurance Co. Name _______________ Customer Service Phone No. _______________

Claims Address _______________ City _______________ State ______ Zip ___________

Group Name _______________ Group No. _______________

(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?

❑ yes ❑ no❑ dk/u Is patient sensitive or self-conscious about teeth?

MEDICAL HISTORY

Now, or in the past, have you had:

❑ yes ❑ no❑ dk/u Birth defects or hereditary problems?

❑ yes ❑ no❑ dk/u Bone fractures, any major accidents?

❑ yes ❑ no❑ dk/u Rheumatoid or arthritic condition?

❑ 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 AIDS or HIV positive?

❑ yes ❑ no❑ dk/u Hepatitis, jaundice or liver problems?

❑ yes ❑ no❑ dk/u Fainting spells, seizures, epilepsy or neurological problem?

❑ 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?

❑ yes ❑ no❑ dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease?

❑ yes ❑ no❑ dk/u Does your child require antibiotic pre-medication prior to dental procedures?

If so, what antibiotic does your physician recommend?

____

❑ yes ❑ no❑ dk/u Skin disorder?

❑ yes ❑ no❑ dk/u Do you have a well-balanced diet?

❑ yes ❑ no❑ dk/u Frequent headaches, colds or sore throats?

❑ yes ❑ no❑ dk/u Eye, ear, nose or throat condition?

❑ yes ❑ no❑ dk/u Hay fever, asthma, sinus trouble or hives?

❑ yes ❑ no❑ dk/u Tonsil or adenoid conditions?

❑ yes ❑ no❑ dk/u Osteoporosis?

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 Acryic

❑ yes ❑ no❑ dk/u Animals

❑ yes ❑ no❑ dk/u Foods (specify) ______________

____

❑ yes ❑ no❑ dk/u Other substances (specify)__________

____

❑ yes ❑ no❑ dk/u Are you currently taking or have you ever taken any intravenous bisphosphonates for serious bone disorders/ cancers, such as Zometa (zolendronic acid), Aredia (pamidronate), Didronel (etidromate)?

❑ yes ❑ no❑ dk/u Are you currently taking or have you ever taken any oral bisphosphonates for osteoporosis, osteopenia or other uses, such as Fosamax (alendronate), Actonel (risendronate), Boniva (ibandronate), Skelid (tiladronate), Didronel (etidronate)? Please name the medication and length of time on the medication.

Medication ______________length of time taken ________

Medication ______________length of time taken ________

❑ yes ❑ no❑ dk/u Are you 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:

____

Do you have any other medical conditions that we should know about? ______________

____

GIRLS ONLY

❑ yes ❑ no❑ dk/u Has the patient started her monthly periods?

❑ yes ❑ no❑ dk/u Is the patient pregnant?

FAMILY MEDICAL HISTORY

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

Bleeding disorders ______________

Diabetes ______________

Arthritis ______________

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 Supernumerary “extra” or congenitally missing teeth?

❑ 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, clicking or locking 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 in chewing or jaw opening?

❑ yes ❑ no ❑ dk/u Aware of loose, broken or missing restoration (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 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 forms 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 ______________________________

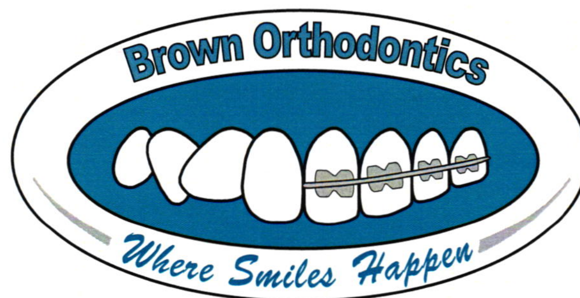
How often does your child brush? ___________________________ floss? ________________________________

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

I have read and understand the above questions. I understand that where appropriate, credit bureau reports may be obtained. 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. If there are any changes later to this history record or medical/ dental status, I will so inform this practice.

Signed: ____ Date Signed: _________________________________

(Parent or Guardian)



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