

TODAY'S DATE _____

MEDICAL DENTAL HISTORY FORM PATIENTS UNDER 18 YEARS OF AGE

Delivering Amazing Smiles & Exceptional Service

CONFIDENTIAL

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 _____

- 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 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 Acrylic
- 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 (zoledronic 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?

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

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Does patient follow directions well? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Polio, mononucleosis, tuberculosis, pneumonia? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Does patient brush his/her teeth conscientiously? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Problems of the immune system? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Does patient have learning disabilities or need extra help? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | AIDS or HIV positive? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Is patient sensitive or self-conscious about teeth? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Hepatitis, jaundice or liver problems? |
| | | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Fainting spells, seizures, epilepsy or neurological problem? |
| | | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Mental health disturbance or depression? |

MEDICAL HISTORY

Now, or in the past, have you had:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Birth defects or hereditary problems? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Vision, hearing, tasting or speech difficulties? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Bone fractures, any major accidents? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Loss of weight recently, poor appetite? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Rheumatoid or arthritic condition? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | History of eating disorder (anorexia, bulimia)? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Endocrine or thyroid problems? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Excessive bleeding or bruising tendency, anemia or bleeding disorder? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Kidney problems? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | High or low blood pressure? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Diabetes? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Tired easily? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Cancer, tumor, radiation treatment, or chemotherapy? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Chest pain, shortness of breath or swelling ankles? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Stomach ulcer or hyperacidity? | | |

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Supernumerary "extra" or congenitally missing teeth? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Difficulty in chewing or jaw opening? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Chipped or otherwise injured primary (baby) or permanent teeth? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Aware of loose, broken or missing restoration (fillings)? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Teeth sensitive to hot or cold; teeth throb or ache? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Any teeth irritating cheek, lip, tongue or palate? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Jaw fractures, cysts or mouth infections? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Concerned about spaced, crooked or protruding teeth? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | "Dead teeth" or root canals treated? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Aware or concerned about under or over developed jaw? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Bleeding gums, bad taste or mouth odor? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | "Gum boils", frequent canker sores or cold sores? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Periodontal "gum problems"? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Taking any forms of fluoride? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Food impaction between teeth? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Any relative with similar tooth or jaw relationships? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Thumb, finger or sucking habit? Until what age _____ ? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Had periodontal (gum) treatment? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Abnormal swallowing habit (tongue thrusting)? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Would you object to wearing orthodontic appliances (braces) should they be indicated? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | History of speech problems? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Any serious trouble associated with any previous dental treatment? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Mouth breathing habit, snoring or difficulty in breathing? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Ever had a prior orthodontic examination or treatment? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Tooth grinding or jaw clenching? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Been under another dentist's care? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Any pain, clicking or locking in jaw or ringing in the ears? | | Specialist _____ |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Any pain or soreness in the muscles of the face or around the ears? | | Other _____ |

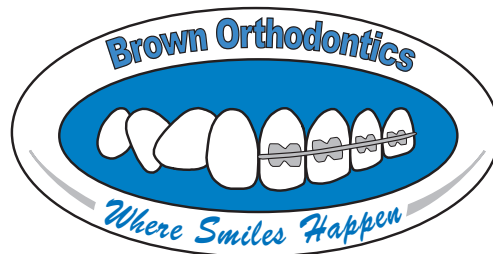
How often does your child brush? _____ floss? _____

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

I have read and understand the above questions. I 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)

Signed: _____ Date Signed: _____
(Dental Staff Member)



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