Medical Dental History Under Age 18

PATIENT

Date ____________
Patient's Last name_____________________________First name___________________________Middle initial____
Birth date __________________
Sex: •Male • Female
I prefer to be called ________________________
Hobbies _________________________________School_____________________________Grade_________________
Home address____City, State, Zip code ____________________________

PARENT/GUARDIAN

Parent/Guardian full name____Relationship to Patient___________________
Address (if different)____Occupation_____________________________
Cell Phone (if different)_____________________Home Phone_______________________Email______________________

Parent/Guardian full name____Relationship to Patient___________________
Address (if different)____Occupation_____________________________
Cell Phone (if different)_____________________Home Phone_______________________Email______________________

DENTIST

Patient's Dentist_________________________________Address, City, State ____
Last seen______________Reason_______________________________________Next appointment ____________________

GENERAL INFORMATION

What concerns you about your child's teeth? ____
How does your child feel about orthodontic treatment? ____
How did you hear about our office? ____
Does your child play a musical instrument? ____
Have any other family members been treated in this office? Please name them.____________________________________

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? ____
Address (if different)______________________________City, State, Zip _
Home phone_________________Cell Phone________________________Email____

DENTAL INSURANCE

Primary policy holder's full name____Birthdate__________________________
_________________ Social Security # - - __________Relationship to patient ____
Address and phone (if not listed above) ____
_________________ Employer____Insurance company _________________
Group #________________________ID # _________________________

PATIENT HEALTH INFORMATION

Does the patient take any pre-medication before any dental procedures? □Yes □No
Does the patient currently have (or ever had) a substance abuse problem? ____________________
Do you think that any of your child's activities have affected his/her face, teeth or jaws? How? ____________________
Does your child chew or smoke tobacco? ____________________
Any other physical problems? ____________________
Please list any medication, supplements or non-prescription medicines, including fluoride supplements that your child takes.
____

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, mark yes or no.

MEDICAL HISTORY

Now or in the past, has the patient had:

□**YES** □**NO** Emotional, sensory or developmental issues?
□**YES** □**NO** Birth defects or hereditary problems?
□**YES** □**NO** Bone fractures, or major injuries?
□**YES** □**NO** Any injuries to face, head, neck?
□**YES** □**NO** Arthritis or joint problems?
□**YES** □**NO** Cancer, tumor, radiation or chemotherapy?
□**YES** □**NO** Endocrine or thyroid problems?
□**YES** □**NO** Diabetes or low sugar?
□**YES** □**NO** Kidney problems?
□**YES** □**NO** Immune system problems?
□**YES** □**NO** History of osteoporosis?
□**YES** □**NO** AIDS or HIV positive?
□**YES** □**NO** Hepatitis, jaundice or other liver problems?
□**YES** □**NO** Polio, mononucleosis, tuberculosis, pneumonia?
□**YES** □**NO** Seizures, fainting spells, neurologic problems?
□**YES** □**NO** Mental health disturbance or depression?
□**YES** □**NO** History of eating disorder?
□**YES** □**NO** Frequent headaches or migraines?
□**YES** □**NO** High or low blood pressure?
□**YES** □**NO** Excessive bleeding or bruising tendency, anemia?
□**YES** □**NO** Does your child eat a well-balanced diet?
□**YES** □**NO** Angina arteriosclerosis, stroke or heart attack?
□**YES** □**NO** Chest pain, shortness of breath, tire easily, swollen ankles?
□**YES** □**NO** Vision, hearing or speech problems?
□**YES** □**NO** Frequent ear infections, colds, throat infections?
□**YES** □**NO** Asthma, sinus problems, hayfever?
□**YES** □**NO** Tonsil or adenoids removed?
□**YES** □**NO** Does your child frequently breathe through his/her mouth?

DENTAL HISTORY

Now or in the past, has the patient had:

□**YES** □**NO** Erupting teeth very early or very late?
□**YES** □**NO** Primary teeth removed that were not loose?
□**YES** □**NO** Permanent or extra teeth removed?
□**YES** □**NO** Extra or congenitally missing teeth?
□**YES** □**NO** Chipped or injured primary or permanent teeth?
□**YES** □**NO** Any sensitive or sore teeth?
□**YES** □**NO** Jaw fractures, cysts, infections?
□**YES** □**NO** Any teeth treated with root canals or pulpotomies?
□**YES** □**NO** Frequent canker sores or cold sores?
□**YES** □**NO** History of speed problems or speech therapy?
□**YES** □**NO** Difficulty breathing through your nose?
□**YES** □**NO** Mouth breathing habit or snoring at night?
□**YES** □**NO** Frequent habit of thumb/finger sucking?
□**YES** □**NO** Frequent habit of tongue thrust?
□**YES** □**NO** Teeth causing irritation to lip, cheek or gums?
□**YES** □**NO** Tooth grinding or clenching?
□**YES** □**NO** Clicking, locking in jaw joins?
□**YES** □**NO** Soreness in jaw muscles or face muscles?
□**YES** □**NO** Has your child been treated for "TMJ" or "TMD"
□**YES** □**NO** Any broken or missing fillings?
□**YES** □**NO** Ever been diagnosed with gum disease?

How often do you brush? ____________________
How often do you floss? ____________________

RELEASE AND WAIVER

I have read the above questions and understand them. I will not hold my orthodontist or any member of his 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:____________________
Dentist Signature:____________________ Date:____________________