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Date____________________

MEDICAL DENTAL HISTORY FORM
PATIENTS UNDER 18 YEARS OF AGE

CONFIDENTIAL

Patient's Last Name:___________________________ First Name:__________________________ Middle Name/Initial:________________

Birth Date:____________________ Age:__________ Sex: M______ F______ Patient's Nickname:_______________________________

S.S.N./S.I.N.:__________________________ Home Phone No.:_________________________

Patient's Address:____

City:_____________________________________ State:____________ Zip/Postal Code:____

Attends School At:____ Grade:_________________________

Musical Instruments Played:____

Sports And/Or Hobbies:____

No. Of Brothers And Sisters:_______________ Ages:____

Other Family Members Treated Here:____

Birth Father's Height:______ft. _______in. Birth Mother's Height:______ft. _______in.

Patient's Birth Weight _____lbs. ______oz. Patient's Present Weight ______lbs. Height:_______ft. _______in.

Custodial Parent(s) Or Guardian(s):____

Phone No.:_________________________ Work No.:_______________________________ Cell No.:_______________________________

Address (if different than patient's):____

City:________________________________ State:____________________________ Zip/Postal Code:_____________________________

E-mail Address:____

Name of Patient's Dentist:____ Phone No.:_________________________________

Dentist's Address:_________________________________ City:________________________ State:____________ Zip:________________

Date Last Seen:___________________ Reason:____

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

Physician's Address:____________________________________ City:____________________ State:_____________ Zip:_______________

Date Last Seen:__________________ Reason:____

Who Is Financially Responsible For This Account?

Last Name:_____________________________________ First Name:_______________________ Middle Name/Initial:_________________

Address:_______________________________________ City:_____________________ State:________________ Zip:___________________

Phone No. :____ S.S.N./S.I.N.:____

Employer:____ How Many Years?_______________________________

Insurance Coverage For Dental Treatment? Yes____ No___ Insurance Coverage For Orthodontic Treatment? Yes___ No___

Primary Policy Holder's Name:______________________________________ S.S.N./S.I.N.:___________________________________

Birth Date:________________ Employed By:____

Dental Insurance Company:____ Group No.:______________________________________

Secondary Policy Holder's Name:___________________________________ S.S.N./S.I.N.:___________________________________

Birth Date:________________ Employed By:____

Dental Insurance Company:____ Group No.:_______________________________________

Medical Insurance Company:____ Group No.:_______________________________________

Who Suggested That Your Child Might Need Orthodontic Treatment?____

Why Did You Select Our Office?____

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?

MEDICAL HISTORY (now or in the past, have you had)

___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 Birth defects or hereditary problems?

___yes ___no ___dk/u Bone fractures, 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 AIDS or HIV positive?

___yes ___no ___dk/u Hepatitis, jaundice or liver problem?

___yes ___no ___dk/u Fainting spells, seizures, epilepsy or neurological problem?

___yes ___no ___dk/u Loss of weight recently, poor appetite?

___yes ___no ___dk/u Skin disorder?

___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 History of eating disorder (anorexia, bulimia)?

___yes ___no ___dk/u Vision, hearing, tasting or speech difficulties?

___yes ___no ___dk/u Mental health disturbance or depression?

___yes ___no ___dk/u Tonsil or adenoid condition?

___yes ___no ___dk/u Does patient eat a well balanced diet?

___yes ___no ___dk/u Hayfever, asthma, sinus trouble, or hives?

___yes ___no ___dk/u Frequent headaches, colds, or sore throats?

___yes ___no ___dk/u Eye, ear, nose or throat condition?

Allergies or reactions to any of the following:

___yes___no___dk/u Local anesthetics (Novocaine or Lidocaine

___yes___no___dk/u Metals (jewelry, clothing snaps)

___yes___no___dk/u Ibuprofen (Motrin, Advil)

___yes___no___dk/u Aspirin

___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 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 (zolendronic acid), Aredia (pamidronate), Didronel (etidronate)?

___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 (tiludronate), 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 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? ____

GIRLS ONLY

___yes___no___dk/u Has the patient started her monthly periods?
If so, approximately when?_________________

___yes___no___dk/u Is the patient pregnant?

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 Teeth sensitive to hot or cold; teeth throb or ache?

___yes___no___dk/u Jaw fractures, cysts or mouth infections?

___yes___no___dk/u Chipped or otherwise injured primary(baby) or permanent teeth?

___yes___no___dk/u “Dead teeth” or root canals treated?

___yes___no___dk/u Thumb, finger or sucking habit? Until what age?_______?

___yes___no___dk/u Bleeding gums, bad taste of mouth odor?

___yes___no___dk/u Mouth breathing habit, snoring, or difficulty in breathing?

___yes___no___dk/u Any pain or soreness in the muscles of the face or around the ears?

___yes___no___dk/u Tooth grinding or jaw clenching?

___yes___no___dk/u Supernumerary (extra) or congenitally missing teeth?

___yes___no___dk/u Any pain in jaw or ringing in the ears?

___yes___no___dk/u Difficulty encountered in chewing or jaw opening?

___yes___no___dk/u Any teeth irritating cheek, lip, tongue or palate?

___yes___no___dk/u Aware or concerned about under or overdeveloped jaw?

___yes___no___dk/u Taking any forms of fluoride?

___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 Been under another dentist's care?

Specialist ____

Other ____

___yes___no___dk/u Periodontal "gum problems"?

___yes___no___dk/u Food impaction between teeth?

___yes___no___dk/u Permanent or "extra" (supernumerary) teeth removed?

____yes___no___dk/u History of speech problems?

___yes___no___dk/u Abnormal swallowing habit (tongue thrusting)?

___yes___no___dk/u Aware of loose, broken or missing restorations (fillings)?

___yes___no___dk/u Concerned about space crooked or protruding teeth?

___yes___no___dk/u "Gum boils", frequent canker sores or cold sores?

___yes___no___dk/u Any relative with similar tooth or jaw relationships?

___yes___no___dk/u Any serious trouble associated with previous dental treatment?

___yes___no___dk/u Ever had a prior orthodontic examination or treatment?

FAMILY MEDICAL HISTORY

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

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 made later to this history record or medical/dental status, I will so inform the practice.

Signed:____ Date Signed:___________________________
(Parent or Guardian)

Signed:____ Date Signed:___________________________
(Dental staff member)