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Medical Dental History Form for Patients Under Age 18

Patient

Date_____

Patient's last name: _____ First name: _____ M.I. _____

Prefers to be called:_____ Hobbies, activities:_____

Birth date: _____ Sex □Male □Female Social Security #:_____

School:_____ Grade:_____ Email Address(es):_____

Home Address: _____

Home phone (_____)_____-_____ Cell Phone (_____)_____-_____

Parent/Guardian

Custodial Parent(s) name(s): _____

Patient lives with (check all that apply) □Mother □Father □Stepmother □Stepfather □Grandparent(s) □Other_____

Father's full name:_____ Title: □Mr. □Dr. □Other_____

Occupation _____ Email address: _____

Address (if different) _____

Home Phone(if different)(_____)_____-_____ Cell Phone (_____)_____-_____Work Phone (_____)_____-_____

Mother's full name:_____ Title: □Mrs.□Ms. □Dr. □Other_____

Occupation _____ Email address: _____

Address (if different) _____

Home Phone(if different)(_____)_____-_____ Cell Phone (_____)_____-_____Work Phone (_____)_____-_____

Dentist

Patient's Dentist _____ Last Seen: _____

Other dentists/dental specialists now being seen: _____ Reason: _____

General Information

What concerns you about your child's teeth? _____

What concerns your child about his/her teeth? _____

How does your child feel about orthodontic treatment? _____

Who suggested that your child might need orthodontic treatment?_____

General information (continued)

Why did you select our office? _____

Describe any previous orthodontic treatment of consultations_____

Sibling name _____ Age_____ Had orthodontic treatment? □Yes □No If yes, where_____

Sibling name _____ Age_____ Had orthodontic treatment? □Yes□No If yes, where_____

Sibling name _____ Age_____ Had orthodontic treatment? □Yes □No If yes, where_____

Financial Responsibility

Who is financially responsible for this account? _____

Address (if different than page 1)_____

Phone (_____)_____-_____Email Address_____Social Security #_____

Employer_____ Who may we release financial information to?_____

Who will be responsible for bringing the patient to orthodontic appointments? _____

Dental Insurance

Primary Policy Holder's Full Name_____ Birth Date_____

Social Security #_____ Relationship to patient_____

Address (if different than page 1)_____

Employer_____ Employer Address_____

Insurance Company_____ Group #_____ ID#_____

Does this policy have orthodontic benefits? □Yes □No □Don't Know

Secondary Policy Holder's Full Name_____ Birth Date_____

Social Security #_____ Relationship to patient_____

Address (if different than page 1)_____

Employer_____ Employer Address_____

Insurance Company_____ Group #_____ ID#_____

Does this policy have orthodontic benefits? □Yes □No □Don't Know

Physician

Patient's Physician_____ City, State_____ Last Seen_____

Reason Last Seen_____ Next Appointment_____Most Recent Physical Exam_____

Other Physicians/Health Care Providers being seen now_____

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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, please mark yes, no, or don't know/understand (dk/u).

Medical History

Now or in the past, has your child had:

Yes No DK/U

□ □ □ Birth defects or hereditary problems?

□ □ □ Any injuries to face, head, neck?

□ □ □ Arthritis or joint problems?

□ □ □ Cancer, tumor, radiation treatment or chemotherapy

□ □ □ Endocrine or thyroid problems?

□ □ □ Diabetes?

□ □ □ Kidney problems?

□ □ □ Immune system problems?

□ □ □ History of osteoporosis?

□ □ □ Gonorrhea, syphilis, herpes, sexually transmitted diseases?

□ □ □ AIDS or HIV positive?

□ □ □ Hepatitis, jaundice, or other liver problems?

□ □ □ Polio, mononucleosis, tuberculosis, pneumonia?

□ □ □ Seizures, fainting spells, neurologic problems?

□ □ □ Mental health disturbance or depression?

□ □ □ History of eating disorder? (anorexia, bulimia)?

□ □ □ Frequent headaches or migraines?

□ □ □ High or low blood pressure?

□ □ □ Excessive bleeding or bruising, anemia?

□ □ □ Heart defects, heart murmur, rheumatic heart disease?

□ □ □ Angina, arteriosclerosis, stroke or heart attack?

□ □ □ Vision, hearing, or speech problems?

□ □ □ Frequent ear infections, colds, throat infections?

□ □ □ Tonsil or adenoid condition?

□ □ □ Asthma

□ □ □ Has your child ever taken intravenous or oral bisphosphonates?

Has your child had allergies or reactions to any of the following?

Yes No DK/U

□ □ □ Local anesthetics (ex: lidocaine, xylocaine)

□ □ □ Latex

□ □ □ Aspirin

□ □ □ Ibuprofen (Motrin, Advil)

□ □ □ Penicillin

□ □ □ Other antibiotics _____

□ □ □ Metals (ex: jewelry, clothing snaps)

□ □ □ Acrylics

□ □ □ Plant pollens

□ □ □ Animals

□ □ □ Foods

□ □ □ Other substances _____

Dental History

Now or in the past, has your child had?

Yes No DK/U

□ □ □ Supernumerary (extra) or congenitally missing teeth?

□ □ □ Chipped or injured primary or permanent teeth?

□ □ □ Any sensitive or sore teeth?

□ □ □ Frequently breath through his/her mouth?

□ □ □ History of speech problems or speech therapy?

□ □ □ Frequent oral habits (sucking finger, chewing pen, etc)?

□ □ □ Tooth grinding or clenching?

□ □ □ Clicking, locking in jaw joints?

□ □ □ Soreness in jaw muscles or face muscles?

□ □ □Has your child been treated for "TMJ" or "TMD" problems?

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Patient Health Information

Do you think that any of your child's activities affect his/her face, teeth or jaws? How? _____

_____

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that your child takes.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Does your child take antibiotic pre-medication before any dental procedures?_____

Does your child have (or ever had) a substance abuse problem? _____

Does your child chew or smoke tobacco? _____

Have you noticed any unusual changes in your child's face or jaws? _____

Any other physical problems? _____

Family Medical History

Have the parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders_____ Diabetes _____

Arthritis _____ Severe allergies _____

Unusual dental problems _____ Jaw size imbalance _____

Other family medical conditions? _____

_____

How often does your child brush? _____ Floss? _____

Release and Waiver

I authorize release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company.

Parent/Guardian Signature _____ Date _____

I have read the above questions and understand them. 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. I will notify my orthodontist of any changes in my child's medical or dental health.

Parent/Guardian Signature _____ Date _____

Medical History Updates or Changes

Changes_____

Parent/Guardian Signature_____Date_____

Dental Staff Signature _____Date_____

Changes_____

Parent/Guardian Signature_____Date_____

Dental Staff Signature _____Date_____