



## Medical Dental History Form for Patients Under Age 18

### PATIENT

Date \_\_\_\_\_

Patient's Last name \_\_\_\_\_ First name \_\_\_\_\_ Middle initial \_\_\_\_\_

Prefers To Be Called \_\_\_\_\_ Hobbies, activities \_\_\_\_\_

Birth date \_\_\_\_\_ Sex: Male  Female  Social Security # \_\_ - \_\_ - \_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ E-mail address(es) \_\_\_\_\_

Home address \_\_\_\_\_ City, State, Zip code \_\_\_\_\_

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 \_\_\_\_\_ Address, City, State \_\_\_\_\_

Last seen \_\_\_\_\_ Reason \_\_\_\_\_ Next appointment \_\_\_\_\_

Other dentists/dental specialists now being seen: Name \_\_\_\_\_ City, State \_\_\_\_\_

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? \_\_\_\_\_

Why did you select our office? \_\_\_\_\_

Describe any previous orthodontic treatment or consultations. \_\_\_\_\_

Does your child play a musical instrument? \_\_\_\_\_

Brother/sister name \_\_\_\_\_ age \_\_\_\_\_ had orthodontic treatment?  Yes  No If yes, where? \_\_\_\_\_

Brother/sister name \_\_\_\_\_ age \_\_\_\_\_ had orthodontic treatment?  Yes  No If yes, where? \_\_\_\_\_

Brother/sister name \_\_\_\_\_ age \_\_\_\_\_ had orthodontic treatment?  Yes  No If yes, where? \_\_\_\_\_

Brother/sister name \_\_\_\_\_ age \_\_\_\_\_ had orthodontic treatment?  Yes  No If yes, where? \_\_\_\_\_

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 from page 1) \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-mail address(es) \_\_\_\_\_

Social Security # \_\_\_\_ - \_\_ - \_\_\_\_ Employer: \_\_\_\_\_

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

## DENTAL INSURANCE

Primary policy holder's full name \_\_\_\_\_ Birthdate \_\_\_\_\_

Social Security # \_\_\_\_ - \_\_ - \_\_\_\_ Relationship to patient \_\_\_\_\_

Address and phone (if not listed above) \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Insurance company \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_

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

Secondary policy holder's full name \_\_\_\_\_ Birthdate \_\_\_\_\_

Social Security # \_\_\_\_ - \_\_ - \_\_\_\_ Relationship to patient \_\_\_\_\_

Address and phone (if not listed above) \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Insurance company \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_

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

## MEDICAL INSURANCE

Policy holder's full name \_\_\_\_\_

Insurance company \_\_\_\_\_

## PHYSICIAN

Patient's Physician \_\_\_\_\_ City, State \_\_\_\_\_

Last seen \_\_\_\_\_ Reason \_\_\_\_\_ Next appointment \_\_\_\_\_

Most recent physical exam \_\_\_\_\_

Other physicians/health care providers being seen now:

Name \_\_\_\_\_ City, State \_\_\_\_\_

Reason \_\_\_\_\_

Name \_\_\_\_\_ City, State \_\_\_\_\_

Reason \_\_\_\_\_

**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?
- yes no dk/u Bone fractures, or major injuries?
- yes no dk/u Any injuries to face, head, neck?
- yes no dk/u Arthritis or joint problems?
- yes no dk/u Cancer, tumor, radiation treatment or chemotherapy?
- yes no dk/u Endocrine or thyroid problems?
- yes no dk/u Diabetes or low sugar?
- yes no dk/u Kidney problems?
- yes no dk/u Immune system problems?
- yes no dk/u History of osteoporosis?
- yes no dk/u Gonorrhea, syphilis, herpes, sexually transmitted diseases?
- yes no dk/u AIDS or HIV positive?
- yes no dk/u Hepatitis, jaundice or other liver problems?
- yes no dk/u Polio, mononucleosis, tuberculosis, pneumonia?
- yes no dk/u Seizures, fainting spells, neurologic problem?
- yes no dk/u Mental health disturbance or depression?
- yes no dk/u History of eating disorder (anorexia, bulimia)?
- yes no dk/u Frequent headaches or migraines?
- yes no dk/u High or low blood pressure?
- yes no dk/u Excessive bleeding or bruising tendency, anemia?
- yes no dk/u Chest pain, shortness of breath, tire easily, swollen ankles?
- yes no dk/u Heart defects, heart murmur, rheumatic heart disease?
- yes no dk/u Angina, arteriosclerosis, stroke or heart attack?
- yes no dk/u Skin disorder (other than common acne)?
- yes no dk/u Does your child eat a well-balanced diet?
- yes no dk/u Vision, hearing, or speech problems?
- yes no dk/u Frequent ear infections, colds, throat infections?
- yes no dk/u Asthma, sinus problems, hayfever?
- yes no dk/u Tonsil or adenoid condition?
- yes no dk/u Does your child frequently breathe through his/her mouth?
- yes no dk/u Has your child ever taken intravenous bisphosphonates such as Zometa (zoledromic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?
- yes no dk/u Has your child ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders?

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

- yes no dk/u Local anesthetics (novocaine, lidocaine, xylocaine)
- yes no dk/u Latex (gloves, balloons)
- yes no dk/u Aspirin
- yes no dk/u Ibuprofen (Motrin, Advil)
- yes no dk/u Penicillin
- yes no dk/u Other antibiotics
- yes no dk/u Metals (jewelry, clothing snaps)
- yes no dk/u Acrylics
- yes no dk/u Plant pollens
- yes no dk/u Animals
- yes no dk/u Foods
- yes no dk/u Other substances

## DENTAL HISTORY

### Now or in the past, has the patient had:

- yes no dk/u Erupting teeth very early or very 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 injured primary or permanent teeth?
- yes no dk/u Any sensitive or sore teeth?
- yes no dk/u Any lost or broken fillings?
- yes no dk/u Jaw fractures, cysts, infections?
- yes no dk/u Any teeth treated with root canals or pulpotomies?
- yes no dk/u Frequent canker sores or cold sores?
- yes no dk/u History of speech problems or speech therapy?
- yes no dk/u Difficulty breathing through nose?
- yes no dk/u Mouth breathing habit or snoring at night?
- yes no dk/u History of speech problems?
- yes no dk/u Frequent oral habits (sucking finger, chewing pen, etc.)?
- yes no dk/u Teeth causing irritation to lip, cheek or gums?
- yes no dk/u Tooth grinding or clenching?
- yes no dk/u Clicking, locking in jaw joints?
- yes no dk/u Soreness in jaw muscles or face muscles?
- yes no dk/u Has your child been treated for "TMJ" or "TMD" problems?
- yes no dk/u Any broken or missing fillings?
- yes no dk/u Any serious trouble associated with previous dental treatment?
- yes no dk/u Has your child ever been diagnosed with gum disease or pyorrhea?

## 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 the patient currently 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

Changes \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Dental Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

Changes \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Dental Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

Changes \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Dental Staff Signature \_\_\_\_\_ Date \_\_\_\_\_