CONFIDENTIAL

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 _____ Age _____ Sex ○ Male ○ Female ○ Transgender ○ Other _____

Social Security #_____-_____-_____

School _____ Grade _____ E-mail address(es) _____

Sports _____ Hobbies _____

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 If other, what is the relationship? _____

Father's full name _____ Title ○ Mr. ○ Dr. ○ Other _____

Occupation _____ Employer _____

Social Security #_____-_____-_____

Email address _____ Address (*if different*) _____

Cell phone (*if different*) (_____) _____-_____ Home phone (_____) _____-_____

Work phone (_____) _____-_____

Mother's full name _____ Title ○ Mrs. ○ Ms. ○ Dr. ○ Other _____

Occupation _____ Employer _____

Social Security #_____-_____-_____

Email address _____ Address (*if different*) _____

Cell phone (*if different*) (_____) _____-_____ Home phone (_____) _____-_____

Work phone (_____) _____-_____

Parents' Marital Status (*check one*) ○ Single ○ Married ○ Divorced ○ Separated ○ Widow(er)

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? _____

Who first noticed this problem? ○ Self ○ Dentist ○ Other When? _____

What do you expect from treatment? _____
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 _____
Cell phone (_____) _____-_____ Home phone (_____) _____-_____
Email address _____
Social Security #_____-_____-_____ Employer _____
Who will be responsible for bringing the patient to orthodontic appointments? _____
Whom may we thank for referring you to this office? _____

I understand that if I choose extended payments for services that a credit report may be necessary.
Sign here: _____ Date: _____

ORTHODONTIC INSURANCE

Primary policy holder's full name _____ Birth date _____
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 _____ Birth date _____
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 _____

PHYSICAN

Patient's Physician _____ Address, 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, mark yes, no, or don't know/understand (dk/u).

PATIENT HEALTH INFORMATION

Do you take antibiotic 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 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 chew or smoke tobacco? _____
Have you noticed any unusual changes in your child's face or jaws? _____
Any other physical problems? _____

MEDICAL HISTORY

Now or in the past, has your child had:

○ yes ○ no ○ dk/u Emotional, sensory, or developmental issues?
○ 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 the 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 problems?
○ 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, hay fever?

○ yes ○ no ○ dk/u Tonsil or adenoids removed?
○ yes ○ no ○ dk/u Does your child frequently breathe through his/her mouth?
○ yes ○ no ○ dk/u Has your child ever taken intravenous medication for bone disorders or cancer such as bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate), or Didronel (etidronate)?
○ yes ○ no ○ dk/u Has your child ever taken oral medication for bone disorders such as bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate), or Didronel (etidronate)?

Has your child had allergies or reactions to any of the following?
○ yes ○ no ○ dk/u Latex (gloves, balloons)
○ yes ○ no ○ dk/u Metals (jewelry, clothing snaps)
○ yes ○ no ○ dk/u Acrylics
○ yes ○ no ○ dk/u Local anesthetics (novocaine, lidocaine, xylocaine)
○ 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 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 habit of thumb/finger sucking?
Current? ○ Yes ○ No
○ yes ○ no ○ dk/u Frequent habit of tongue thrust?
Current? ○ Yes ○ No
○ yes ○ no ○ dk/u Frequent habit of fingernail biting?
Current? ○ Yes ○ No
○ yes ○ no ○ dk/u Frequent habit of lip sucking?
Current? ○ Yes ○ No
○ yes ○ no ○ dk/u Any difficult opening mouth wide?
○ yes ○ no ○ dk/u Has the patient ever had an unpleasant experience in a dental office?
○ 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 serious trouble associated with previous dental treatment?
○ yes ○ no ○ dk/u Has your child ever been diagnosed with gum disease or pyorrhea?

How often does your child brush? _____
Floss? _____

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? _____

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 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 _____