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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, sports _____

Birth date _____ Sex: Male ☐ Female ☐ Social Security # _____ - ____ - _____

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

Home address _____ City _____ State _____ Zip code _____

Home phone (_____)_____ Cell phone (_____)_____ Work 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 _____

Social Security # _____ - ____ - _____ Birthdate _____ Email address _____

Address (*if different than patient address)* _____

Home phone (*if different):* (_____)_____ Cell phone (_____)_____ Work phone (_____)_____

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

Social Security # _____ - ____ - _____ Birthdate _____ Email address _____

Address (*if different than patient address)* _____

Home phone (*if different):* (_____)_____ Cell phone (_____)_____ Work phone (_____)_____

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

FINANCIAL RESPONSIBILTY

Who is financially responsible for this account? _____

Address (*if different than patient address)* _____

Home phone (_____)_____ Cell phone (_____)_____ E-mail address(es) _____

Social Security # _____ - ____ - _____ Employer: _____

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

DENTIST *(If patient does not currently see a general dentist please check here ☐)*

Patient's Dentist _____ Address_____

Last seen _____ Reason _____

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? _____

Have any other family members been treated in this office? Please name them. _____

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? _____

MEDICAL INSURANCE

Policy holder's full name _____

Insurance company _____

PHYSICIAN

Patient's Physician _____ Address_____

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).***

MEDICAL HISTORY

Now or in the past, have you 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** Endocrine or thyroid problems?
❑**yes** ❑**no** ❑**dk/u** Diabetes or low sugar?
❑**yes** ❑**no** ❑**dk/u** Kidney problems?
❑**yes** ❑**no** ❑**dk/u** Cancer, tumor, radiation treatment or chemotherapy?
❑**yes** ❑**no** ❑**dk/u** Immune system problems?
❑**yes** ❑**no** ❑**dk/u** History of osteoporosis?
❑**yes** ❑**no** ❑**dk/u** Gonorrhea, syphilis, herpes, STD's?
❑**yes** ❑**no** ❑**dk/u** AIDS or HIV positive?
❑**yes** ❑**no** ❑**dk/u** Hepatitis, jaundice or other liver problem?
❑**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** Vision, hearing, or speech problems?
❑**yes** ❑**no** ❑**dk/u** History of eating disorder (anorexia, bulimia)?
❑**yes** ❑**no** ❑**dk/u** High or low blood pressure?
❑**yes** ❑**no** ❑**dk/u** Excessive bleeding or bruising, anemia?
❑**yes** ❑**no** ❑**dk/u** Chest pain, short 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** Frequent headaches or migraines?
❑**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 (zolendromic 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?

Have you had allergies or reactions to any of the following:

❑**yes** ❑**no** ❑**dk/u** Local anesthetics (Novocain, 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** Metal (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, have you 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** Jaw fractures, cysts, infections?
❑**yes** ❑**no** ❑**dk/u** Any teeth treated with root canals or pulpotomies?
❑**yes** ❑**no** ❑**dk/u** "Gum boils," 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 pens, 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 associate with previous dental treatment?
❑**yes** ❑**no** ❑**dk/u** Has your child ever been diagnosed with gum disease or pyorrhea?
❑**yes** ❑**no** ❑**dk/u** Have you ever had an orthodontic consultation or treatment before now?

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 medication 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 your 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 _____