

# MEDICAL DENTAL HISTORY FORM

## FOR PATIENTS UNDER AGE 18

### PATIENT

**CONFIDENTIAL**

Date \_\_\_\_\_

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

Prefers to be called \_\_\_\_\_ Hobbies, activities \_\_\_\_\_

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

School \_\_\_\_\_ Grade \_\_\_\_\_ Email 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 than page 1) \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Email address(es) \_\_\_\_\_

Social Security # \_\_\_\_\_ Employer \_\_\_\_\_

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 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 \_\_\_\_\_

## 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?
- Bone fractures or major injuries?
- Any injuries to face, head, neck?
- Arthritis or joint problems?
- Cancer, tumor, radiation treatment or chemotherapy?
- Endocrine or thyroid problems?
- Diabetes or low sugar?
- 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?
- Chest pain, shortness of breath, tire easily, swollen ankles?
- Heart defects, heart murmur, rheumatic heart disease?
- Angina, arteriosclerosis, stroke or heart attack?
- Skin disorder (other than common acne)?
- Does your child eat a well-balanced diet?
- Vision, hearing, or speech problems?
- Frequent ear infections, colds, throat infections?
- Asthma, sinus problems, hayfever?
- Tonsil or adenoid condition?
- Does your child frequently breathe through his/her mouth?
- Has your child ever taken intravenous bisphosphonates such as Zometa (zoledronic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?
- 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)
- Latex (gloves, balloons)
- Aspirin
- Ibuprofen (Motrin, Advil)
- Penicillin
- Other antibiotics
- Metals (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

- Erupting teeth very early or very late?
- Primary (baby) teeth removed that were not loose?
- Permanent or extra (supernumerary) teeth removed?
- Supernumerary (extra) or congenitally missing teeth?
- Chipped or injured primary or permanent teeth?
- Any sensitive or sore teeth?
- Any lost or broken fillings?
- Jaw fractures, cysts, infections?
- Any teeth treated with root canals or pulpotomies?
- Frequent canker sores or cold sores?
- History of speech problems or speech therapy?
- Difficulty breathing through nose?
- Mouth breathing habit or snoring at night?
- History of speech problems?
- Frequent oral habits (sucking finger, chewing pen, etc)?
- Teeth causing irritation to lip, cheek or gums?
- 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?
- Any broken or missing fillings?
- Any serious trouble associated with previous dental treatment?
- 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 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 \_\_\_\_\_

Changes \_\_\_\_\_

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

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