Date: _____

CONFIDENTIAL

MEDICAL DENTAL HISTORY FORM FOR PATIENTS UNDER 18 YEARS OF AGE

PATIENT

Last name _____ First name _____ Middle initial _____

Birth date _____ Name I prefer to be called _____

What sex was the patient assigned at birth? Male □ Female □ SS# _____

Home address _____

City/State/Zip _____

School _____ Grade _____

Hobbies/activities _____

PATIENT / GUARDIAN

Custodial parent(s) name(s) _____

Patient lives with (check all that apply) □ Parent/Guardian 1 □ Parent/Guardian 2

Parent/Guardian 1 name _____ Cell phone _____

Address (if different) _____

City/State/Zip _____

Email address _____ Occupation _____

Parent/Guardian 2 name _____ Cell phone _____

Address (if different) _____

City/State/Zip _____

Email address _____ Occupation _____

DENTIST

Patient's dentist _____ Phone number _____

Address _____

City/State/Zip _____

Date last seen _____ Reason _____

Other dentists/dental specialists currently being seen _____

Address _____

City/State/Zip _____

Reason _____

PHYSICIAN

Patient's physician _____ Phone number _____

Address _____

City/State/Zip _____

Other physicians/health care professionals being seen now

Name _____ Reason _____

Name _____ 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 _____

Sibling name _____ Age _____ Had ortho treatment □ Yes □ No If yes, where? _____

Sibling name _____ Age _____ Had ortho treatment □ Yes □ No If yes, where? _____

Sibling name _____ Age _____ Had ortho treatment □ Yes □ No If yes, where? _____

Have we treated any family members? Please name _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account?

Last name _____ First name _____ Middle initial _____

Address (if different from page 1) _____

City/State/Zip (if different than page 1) _____

Email address _____ Cell phone _____

Employer _____ SS# _____

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

DENTAL INSURANCE

Primary policy holder's name _____ Date of birth _____

SS# _____ Relationship to patient _____

Insurance company _____ Group number _____

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

Secondary policy holder's name _____ Date of birth _____

SS# _____ Employer _____

Insurance company _____ Group number _____

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

MEDICAL INSURANCE

Primary policy holder's name _____ Date of birth _____

SS# _____ Relationship to patient _____

Insurance company _____ Group number _____

For the following questions, mark yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

PATIENT HEALTH INFORMATION

Does the patient take antibiotic pre-medication before any dental procedures? □ Yes □ No

Does the patient currently have (or ever had) a substance abuse problem? □ Yes □ No

Do you think 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 _____ Medication _____ Taken for _____

Does your child chew/smoke tobacco or vape? □ Yes □ No If yes, please specify _____

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 or sensory issues?
□yes □no □dk/u Hereditary or developmental conditions?
□yes □no □dk/u Bone fractures or major injuries?
□yes □no □dk/u Any injuries to face, head, or 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, or other sexually transmitted disease?
□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, or pneumonia?
□yes □no □dk/u Seizures, fainting spells, or 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 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 Tonsils 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 IV medication for bone disorders or cancer such as bisphosphonates 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 Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate)?

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 substance _____

DENTAL HISTORY

Now or in the past, has your child 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 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 Age stopped _____
□yes □no □dk/u Frequent habit of tongue thrust?
Current □yes □no Age stopped _____
□yes □no □dk/u Frequent habit of fingernail biting?
Current □yes □no
Age stopped _____
□yes □no □dk/u Frequent habit of lip sucking?
Current □yes □no
Age stopped _____
□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? _____

How often does your child floss? _____

FAMILY MEDICAL HISTORY

Have the child's 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.

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.

Signature _____ Date _____

MEDICAL HISTORY UPDATES OR CHANGES

Changes _____

Patient signature _____ Date signed: _____

Dental staff signature _____ Date signed: _____