

CONFIDENTIAL

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MEDICAL DENTAL HISTORY FORM
FOR PATIENTS UNDER 21 YEARS OF AGE

Date _____

Patient's Last Name _____ First _____ Middle _____

Birth date _____ Age _____ Sex _____ Height _____ Weight _____

Patient's Address - Street _____

City _____ State _____ Zip _____ How long at this address? _____ Own _____ Rent _____

Parent E-mail address _____ Patient E-mail address _____

Parent Cell Phone # _____ () _____ Patient Cell Phone# _____ () _____

Hobbies _____ Home Phone # with area code _____ () _____

Father's Name _____ Social Security # _____ DOB: _____

Workplace _____ Position _____

Business Address _____

Business Phone # _____ () _____ How long employed at this workplace? _____

Mother's Name _____ Social Security # _____ DOB: _____

Workplace _____ Position _____

Business Address _____

Business Phone # _____ () _____ How long employed at this workplace? _____

Parents are: Single _____ Married _____ Widowed _____ Separated _____ Divorced _____

Legal Guardian/Parent/Custodial Parent _____

Father and/or Mother Address & Telephone # if different from Patient's _____

What is the patient's (or parent's) primary concern? Reason you are here? _____

Other Family Members Treated _____

Who may we thank for referring you to the office? 1) _____ 2) _____

Dentist _____ Physician _____

Patient's School _____ Grade _____

In case we cannot reach you: Person to contact (non parent) _____ Phone # _____ () _____

Dental Insurance No _____ Yes _____ Name & Phone # of Insurance Co. _____

Name of Policy Holder _____ DOB Policy Holder _____ SS# _____

If you have orthodontics insurance, please provide the front desk your dental insurance card to copy.

Secondary Dental Insurance No _____ Yes _____ Name & Phone # of Insurance Co. _____

Name of Policy Holder _____ DOB Policy Holder _____ SS# _____

For the following questions, circle 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.

Table with 3 columns: yes, no, dk/u. Rows include: MEDICAL HISTORY, Hepatitis, jaundice, or liver problems?; Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects or rheumatic heart?); Heart murmur? (currently?); Diabetes?; Excessive bleeding, black and blue tendency, anemia, or bleeding disorder?; Allergies or drug reactions?; Are you taking medication, nutrient supplements or non-prescription medicine? Please name them.; Thumb or finger sucking habit? Until age; Abnormal swallowing habit (tongue thrusting?); History of speech problems?;

- yes no dk/u Tooth grinding, jaw clenching?
- yes no dk/u Mouth breathing habit, snoring, difficulty in breathing?
(Please circle appropriately)
- yes no dk/u History of trauma to face or teeth?
- yes no dk/u Any pain in jaw, clicking, or locking? *(Please circle)*
- yes no dk/u Difficulty encountered in chewing or jaw opening?
- yes no dk/u Does the patient experience any pain or soreness in the muscles of the face or around the ears?
- yes no dk/u Birth defects or hereditary problems?
- yes no dk/u Rheumatoid or arthritic conditions?
- yes no dk/u Endocrine or thyroid problems?
- yes no dk/u Kidney problems?
- yes no dk/u Cancer or been treated for a tumor?
- yes no dk/u Problems of the immune system?
- yes no dk/u AIDS or HIV positive?
- yes no dk/u Fainting spells, seizures, epilepsy or neurologic problem?
- yes no dk/u Mental health or behavioral problem?
- yes no dk/u High or low blood pressure?
- yes no dk/u Frequent headaches, colds or sore throats?
- yes no dk/u Eye, ear, nose, throat condition?
- yes no dk/u Hayfever, asthma, sinus trouble, hives?
- yes no dk/u Tonsil or adenoid condition?
- yes no dk/u Does the patient currently have or ever had a substance abuse problem?
- yes no dk/u Operations? (surgical procedures)? _____
- yes no dk/u Hospitalized for _____
- yes no dk/u Being treated by another health care professional? For _____

Date of most recent exam? _____

DENTAL HISTORY

Date of your most recent dental exam? _____

- yes no dk/u Concerned about space, crooked, protruded teeth, etc?
- yes no dk/u Aware or concerned about under or over developed jaw?
- yes no dk/u Any relative with similar tooth or jaw relationships?
- yes no dk/u Has the patient had any serious trouble associated with any previous dental treatment?
- yes no dk/u Onset of puberty? (approximate date)? _____

- yes no dk/u Has patient ever had a prior orthodontic examination or treatment?
- yes no dk/u Has patient recently been under another dentist's care?
Specialist _____
Other _____
- yes no dk/u Has patient ever had periodontal (gum) treatment?
- yes no dk/u Does patient have trouble brushing his/her teeth consistently?
- yes no dk/u Does patient have learning disabilities or need extra help with instructions?
- yes no dk/u Would patient object to wearing braces?
- yes no dk/u Started teething very early or late? *(circle one)*
- yes no dk/u Congenitally missing teeth?
- yes no dk/u Chipped or otherwise injured primary (baby) or permanent teeth?
- yes no dk/u Teeth sensitive to hot or cold; teeth throb or ache?
- yes no dk/u Jaw fractures, cysts, mouth infections?
- yes no dk/u "Dead teeth", root canals treated?
- yes no dk/u Bleeding gums, bad taste, mouth odor?
- yes no dk/u "Gum boils", frequent canker sores, cold sores?

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments and maintaining good oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment?

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice. I understand where appropriate a credit report may be obtained.

Signature of parent or guardian _____ Date _____

If patient is 18 - 21 years of age:

SS# _____ Workplace _____

Position _____ Business Phone _____

How long employed at this workplace _____

Business Address: _____

Signature of Patient _____ Date _____