MEDICAL DENTAL HISTORY FORM

FOR PATIENTS UNDER 18 YEARS OF AGE

WELCOME TO OUR OFFICE!

Date _____

Patient's Name _____
Last *First* *Middle*

Address _____
Street *City* *State* *Zip*

Home Phone _____ Birth Date _____ Social Security # _____

If patient is minor, give parent or guardian's name _____

Patient: _____ Responsible Party: _____
Email Address *Email Address*

Do you prefer an *email* or *text message* to remind you of appointments? ☐ Email ☐ Text (_____)_____-_____

RESPONSIBLE PARTY INFORMATION

Name _____
Last *First* *Middle* *Marital Status*

Residence _____
Street *City* *State* *Zip*

Mailing Address _____
Street *City* *State* *Zip*

How long at this address _____ Home Phone _____ Work Phone _____

Cell Phone _____ Alternate Phone _____

Previous Address (if less than 3 years) _____
Street *City* *State* *Zip*

Social Security # _____ Birth Date _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last *First* *Middle*

Spouse's Employer _____ Occupation _____ No. Years Employed _____

Spouse's Social Security # _____ Spouse's Birth Date _____

INSURANCE INFORMATION

Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group # _____ Local No. _____
Insurance Co. Address _____
Do you have dual coverage? Yes ☐ No ☐ If Yes, please continue: _____
Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group # _____ Local No. _____
Insurance Co. Address _____
Insured's Employer _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____
Complete Address _____
Phone _____ Relationship to Patient _____

Signature (Parent's signature, if minor) _____ Date _____

I understand that where appropriate, credit bureau reports may be obtained. I understand and agree that I am responsible for payment. I certify this information is true and correct to the best of my knowledge.

Name_____

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.

MEDICAL HISTORY

Now or in the past, has the patient had:

☐ **yes** ☐ **no** ☐ **dk/u** Birth defects or hereditary problems?
☐ **yes** ☐ **no** ☐ **dk/u** Bone fractures, any major accidents?
☐ **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** Diabetes? If yes, Type I or Type II?
☐ **yes** ☐ **no** ☐ **dk/u** Cancer, tumor, radiation treatment or chemotherapy?
☐ **yes** ☐ **no** ☐ **dk/u** Stomach ulcer or hyperacidity?
☐ **yes** ☐ **no** ☐ **dk/u** Polio, mononucleosis, tuberculosis or pneumonia?
☐ **yes** ☐ **no** ☐ **dk/u** Problems of the immune system?
☐ **yes** ☐ **no** ☐ **dk/u** AIDS or HIV positive?
☐ **yes** ☐ **no** ☐ **dk/u** Hepatitis, jaundice or liver problem?
☐ **yes** ☐ **no** ☐ **dk/u** Fainting spells, seizures, epilepsy or neurological problem?
☐ **yes** ☐ **no** ☐ **dk/u** Mental health disturbance or behavioral problem?
☐ **yes** ☐ **no** ☐ **dk/u** Vision, hearing, tasting or speech difficulties?
☐ **yes** ☐ **no** ☐ **dk/u** Loss of weight recently, poor appetite?
☐ **yes** ☐ **no** ☐ **dk/u** History of eating disorder (anorexia, bulimia)?
☐ **yes** ☐ **no** ☐ **dk/u** Excessive bleeding or bruising tendency, anemia or bleeding disorder?
☐ **yes** ☐ **no** ☐ **dk/u** High or low blood pressure?
☐ **yes** ☐ **no** ☐ **dk/u** Tires easily?
☐ **yes** ☐ **no** ☐ **dk/u** Chest pain, shortness of breath or swelling ankles?
☐ **yes** ☐ **no** ☐ **dk/u** Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
☐ **yes** ☐ **no** ☐ **dk/u** Skin disorder?
☐ **yes** ☐ **no** ☐ **dk/u** Does the patient eat a well-balanced diet?
☐ **yes** ☐ **no** ☐ **dk/u** Frequent headaches, colds or sore throats?
☐ **yes** ☐ **no** ☐ **dk/u** Eye, ear, nose or throat condition?
☐ **yes** ☐ **no** ☐ **dk/u** Tonsil or adenoid conditions?
☐ **yes** ☐ **no** ☐ **dk/u** Hayfever, asthma, sinus trouble?

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** Local anesthetics, such as Lidocaine
☐ **yes** ☐ **no** ☐ **dk/u** Acrylic
☐ **yes** ☐ **no** ☐ **dk/u** Medications (please specify)_____
☐ **yes** ☐ **no** ☐ **dk/u** Foods (please specify) _____
☐ **yes** ☐ **no** ☐ **dk/u** Other substances (specify) _____

☐ **yes** ☐ **no** ☐ **dk/u** Is the patient taking medication, nutrient supplements, herbal medications or non-prescription medicine?
If yes, please name them:
Medication_____ Taken for_____
Medication_____ Taken for_____

☐ **yes** ☐ **no** ☐ **dk/u** Does the patient currently have or ever had a substance abuse problem?
☐ **yes** ☐ **no** ☐ **dk/u** Does the patient smoke or chew tobacco?
☐ **yes** ☐ **no** ☐ **dk/u** Operations? Describe: _____
☐ **yes** ☐ **no** ☐ **dk/u** Hospitalized? For: _____
☐ **yes** ☐ **no** ☐ **dk/u** Being treated by another health care professional? If yes, for: _____
☐ **yes** ☐ **no** ☐ **dk/u** Other physical problems or symptoms?
Describe: _____
Are there any other medical conditions (including family medical conditions) that we should be aware of?_____

PATIENT PROFILE

☐ **yes** ☐ **no** ☐ **dk/u** Does patient follow directions well?
☐ **yes** ☐ **no** ☐ **dk/u** Does patient brush his/her teeth conscientiously?
☐ **yes** ☐ **no** ☐ **dk/u** Does patient have learning disabilities or need extra help with instructions?
☐ **yes** ☐ **no** ☐ **dk/u** Is patient self-conscious about teeth?

DENTAL HISTORY

General Dentist's Name: _____

Now or in the past, has the patient had:

☐ **yes** ☐ **no** ☐ **dk/u** Started teething very early or 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 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 or mouth infections?
☐ **yes** ☐ **no** ☐ **dk/u** "Dead teeth" or root canals treated?
☐ **yes** ☐ **no** ☐ **dk/u** Bleeding gums, bad taste or mouth odor?
☐ **yes** ☐ **no** ☐ **dk/u** Periodontal "gum problems"?
☐ **yes** ☐ **no** ☐ **dk/u** Food impaction between teeth?
☐ **yes** ☐ **no** ☐ **dk/u** Thumb, finger, or sucking habit?
Until what age ?_____
☐ **yes** ☐ **no** ☐ **dk/u** Abnormal swallowing habit (tongue thrusting)?
☐ **yes** ☐ **no** ☐ **dk/u** History of speech problems?
☐ **yes** ☐ **no** ☐ **dk/u** Mouth breathing habit, snoring or difficulty in breathing?
☐ **yes** ☐ **no** ☐ **dk/u** Tooth grinding, jaw clenching clicking or locking?
☐ **yes** ☐ **no** ☐ **dk/u** Any pain in jaw or ringing in the ears?
☐ **yes** ☐ **no** ☐ **dk/u** Any pain or soreness in the muscles of the face or around the ears?
☐ **yes** ☐ **no** ☐ **dk/u** Difficulty encountered in chewing or jaw opening?
☐ **yes** ☐ **no** ☐ **dk/u** Aware of loose, broken or missing restorations (fillings)?
☐ **yes** ☐ **no** ☐ **dk/u** Any teeth irritating cheek, lip, tongue or palate?
☐ **yes** ☐ **no** ☐ **dk/u** Concerned about spaced, crooked or protruding teeth?
☐ **yes** ☐ **no** ☐ **dk/u** Aware or concerned about under or over developed jaw?
☐ **yes** ☐ **no** ☐ **dk/u** "Gum Boils", frequent canker sores or cold sores?
☐ **yes** ☐ **no** ☐ **dk/u** Taking any forms of fluoride?
☐ **yes** ☐ **no** ☐ **dk/u** Any relative with similar tooth or jaw relationships?
☐ **yes** ☐ **no** ☐ **dk/u** Had periodontal (gum) treatment?
☐ **yes** ☐ **no** ☐ **dk/u** Would patient object to wearing orthodontic appliances (braces) should they be indicated?
☐ **yes** ☐ **no** ☐ **dk/u** Any serious trouble associated with any previous dental treatment?
☐ **yes** ☐ **no** ☐ **dk/u** Ever had a prior orthodontic examination or treatment?
☐ **yes** ☐ **no** ☐ **dk/u** Been under another dentist's care?

GIRLS ONLY

☐ **yes** ☐ **no** ☐ **dk/u** Has the patient started her monthly periods?
If so, approximately when? _____
☐ **yes** ☐ **no** ☐ **dk/u** Is the patient pregnant?

Who may we thank for referring you to our office?

_____

Name of Patient's school:

_____

Sports/Hobbies:

_____

American Association of Orthodontists