MEDICAL DENTAL HISTORY FORM- FOR PATIENTS UNDER 18 YEARS OF AGE

Date:_____

CONFIDENTIAL

Patient's Last Name:_____ First Name:_____ Middle Name/Initial:_____
Birth date:_____ Age:_____ Sex: Male □ Female □ Preferred Name:_____
Home Phone No.:_____ Cell No.:_____
Patient's Address:_____ E-mail Address:_____
City:_____ State:_____ Zip Code:_____
Attends School At:_____ Grade:_____
Musical Instruments Played:_____ Sports And/or Hobbies:_____
No. of Brothers & Sisters:_____ Ages_____ Other family members treated here:_____
Parent Mr.□ Mrs.□ Ms.□ Dr.□_____ Parent Mr.□ Mrs.□ Ms.□ Dr.□_____
Legal Guardian Mr.□ Mrs.□ Ms.□ Dr.□_____
Parents: □ Single □ Married □ Separated □ Divorced □ Widowed Is patient Adopted?_____
Phone No.(if different from patient's):_____ Address (if different from patient's)_____
City:_____ State_____ Zip Code:_____
E-mail Address:_____ Cell phone/pager_____
Name Of Patient's Dentist:_____ Date Last Seen:_____
Name Of Patient's Physician:_____ Date Last Seen:_____
Who is Financially Responsible For This Account? Name:_____
Address (if different from patient's)_____
City:_____ State:_____ Zip Code:_____
Phone No.(if different from patient's):_____
Employer:_____
Insurance Coverage for Dental Treatment? Yes □ No □ Insurance Coverage for orthodontic Treatment? Yes □ No □
Policy Holder's Name:_____ S.S.N./ID#_____
Birth date:_____ Employer:_____
Dental Insurance Company:_____ Group No.:_____
Who suggested that you might need orthodontic treatment?_____ Referred By:_____

PATIENT PROFILE

□ Yes □ No Does patient follow directions well?
□ Yes □ No Does patient brush his/her teeth Conscientiously?
□ Yes □ No Does the patient have learning disabilities or need extra help with instructions?
□ Yes □ No Is Patient sensitive or self-conscious about teeth?

MEDICAL HISTORY

Now or in the past, have you had:

□ Yes □ No Birth defects or hereditary problems?
□ Yes □ No Bone fractures, any major accidents?
□ Yes □ No Rheumatoid or arthritic conditions?
□ Yes □ No Endocrine or thyroid problems?
□ Yes □ No Kidney problems?
□ Yes □ No Diabetes?
□ Yes □ No Cancer, tumor, radiation or chemotherapy?
□ Yes □ No Stomach ulcer or hyperacidity?
□ Yes □ No Polio, mononucleosis, tuberculosis, pneumonia?
□ Yes □ No Problems of the immune system?
□ Yes □ No AIDS or HIV Positive?
□ Yes □ No Hepatitis, jaundice, or liver problems?
□ Yes □ No Fainting spells, seizures, epilepsy or neurological problems?
□ Yes □ No Mental health disturbance or depression?
□ Yes □ No Vision, hearing, testing or speech difficulties?
□ Yes □ No Loss of weight recently, poor appetite?
□ Yes □ No History of eating disorders (anorexia, bulimia)?
□ Yes □ No Excessive bleeding or brushing tendency, anemia or bleeding disorder?
□ Yes □ No High or low blood pressure?
□ Yes □ No Tires Easily?
□ Yes □ No Chest pain, shortness of breath or swollen ankles?
□ Yes □ No Cardiovascular problem (heart trouble, heart attack angina coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
□ Yes □ No Skin Disorder?
□ Yes □ No Does the patient eat a well-balanced diet?
□ Yes □ No Frequent headaches, colds or sore throats?
□ Yes □ No Eye, ear, nose, throat condition?
□ Yes □ No Hay fever, asthma, sinus trouble or hives?
□ Yes □ No Tonsil or adenoid condition?

Allergies or reactions to any of the following:

□ Yes □ No Local anesthetics (Novocaine or Lidocaine)
□ Yes □ No Aspirin
□ Yes □ No Ibuprofen (Motrin, Advil)
□ Yes □ No Penicillin or other antibiotics
□ Yes □ No Sulfa drugs
□ Yes □ No Codeine or other narcotics
□ Yes □ No Metals (jewelry, clothing snaps)
□ Yes □ No Latex (gloves, balloons)
□ Yes □ No Vinyl
□ Yes □ No Acrylic
□ Yes □ No Animals
□ Yes □ No Foods (specify)_____
□ Yes □ No Other Substances (specify)_____
□ Yes □ No Is the patient taking medication, nutrient supplements, herbal medications or non-prescription medicine? Please name.

Medication _____ Taken for_____

Medication _____ Taken for_____

Medication _____ Taken for_____

□ Yes □ No Does the patient have or ever had a substance abuse problem?
□ Yes □ No Does the patient chew or smoke tobacco?
□ Yes □ No Operations? Describe: _____
_____
□ Yes □ No Hospitalized? Describe: _____
_____
□ Yes □ No Other physical problems or symptoms? Describe: _____
_____
□ Yes □ No Being treated by another health care professional?
For: _____
Date of most recent physical exam? _____
Are there any other medical conditions that we should know about?
_____
_____

GIRLS ONLY

□ Yes □ No Has the patient started her monthly periods?
If so, approximately when? _____
□ Yes □ No Is the patient pregnant?

FAMILY MEDICAL HISTORY

Do the patient's parents or siblings have any of the following health problems? If so, please explain.
Bleeding disorders: _____
Diabetes: _____
Arthritis: _____
Metabolic disturbances: _____
Severe allergies: _____
Unusual dental problems: _____
Jaw size imbalances: _____
Any other family medical conditions that we should know about?
_____

How often does your child brush: _____ Floss: _____
Date of last dental exam: _____
What is your primary concern? Why are you here? _____
_____

DENTAL HISTORY

Now or in the past, has the patient had:

□ Yes □ No Thumb, finger, or sucking habit? Until what age? _____
□ Yes □ No Abnormal swallowing habit (tongue thrusting)?
□ Yes □ No History of speech problems?
□ Yes □ No Mouth breathing habit, snoring or difficulty breathing?
□ Yes □ No Started teething very early or late?
□ Yes □ No Primary (baby) teeth removed that were not loose?
□ Yes □ No Permanent or extra (supernumerary) teeth removed?
□ Yes □ No Extra (supernumerary) or congenitally missing teeth?
□ Yes □ No Chipped or otherwise injured primary (baby) or permanent teeth?
□ Yes □ No Teeth sensitive to hot or cold: teeth throb or ache?
□ Yes □ No Jaw fractures, cysts or mouth infections?
□ Yes □ No "Dead teeth" or root canal treated teeth?
□ Yes □ No Bleeding gums, bad taste or mouth odor?
□ Yes □ No Periodontal (gum) problems?
□ Yes □ No Food impaction between teeth?
□ Yes □ No Aware of loose, broken or missing restorations (fillings)?
□ Yes □ No Any teeth irritating cheek, lip, tongue or palate?
□ Yes □ No Concerned about spaces, crooked or protruding teeth?
□ Yes □ No Aware or concerned about under or over developed jaw?
□ Yes □ No Frequent canker sores or cold sores?
□ Yes □ No Taking any forms of Fluoride?
□ Yes □ No Any relative with similar tooth or jaw relationships?
□ Yes □ No Had periodontal (gum) treatment?
□ Yes □ No Would you object to wearing orthodontic appliances (braces) should they be indicated?
□ Yes □ No Any serious trouble associated with any previous dental treatment?
□ Yes □ No Ever had a prior orthodontic examination or treatment?
□ Yes □ No Been under another dentist's care?
Specialist: _____
□ Yes □ No Tooth grinding or jaw clenching habit?
□ Yes □ No Any pain in jaw or ringing in the ears?
□ Yes □ No Any pain or soreness in the muscles of the face or around the ears?
□ Yes □ No Difficulty encountered in chewing or jaw opening?

I have read and understand the above questions. I will not hold my orthodontist or any staff member 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 inform this practice.

Signed: _____ Date Signed: _____ Signed: _____ Date Signed: _____
(Parent or Guardian) (Dental Staff Member)

Class: _____ Div: _____
Open Bite: _____ Close Bite: _____
A.L. Disc.: _____ Overjet: _____
HABITS: Finger □ Thumb □ Mouth Breather □ Tongue Thrust □
Eruption Pattern: Early □ Late □

PROFILE: SAT □ RETR □ FLAT □ BIMAX □ CONCAVE □
LIPS: Together □ Apart □
CHIN: Protruded □ Retruded □
NOSE: Aver □ Large □ Small □
ABNORMAL FRENUM: Max □ Mand □
TMJ CLICK: Right □ Left □ Symp □ Asymp □

TREATMENT

Phase 1 Active Lim Tx

Missing: _____/_____
Crossbite: _____/_____
Fee Book Date
Length of Treatment

Letters	□ Referral	□ Diagnostic	□ Contract	□ Completion	□	□