



# Medical Dental History Form for Patients Under Age 18

## PATIENT

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 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 \_\_\_\_\_