

**CONFIDENTIAL**

**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 \_\_\_\_ E-mail 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 If other, what is the relationship? \_\_\_\_\_  
Father's full name \_\_\_\_\_ Title  Mr.  Dr.  Other \_\_\_\_\_  
Occupation \_\_\_\_\_ Email address \_\_\_\_\_  
Address (*if different*) \_\_\_\_\_  
Cell Phone (*if different*): \_\_\_\_\_ Home phone \_\_\_\_\_  
Work phone \_\_\_\_\_

Mother's full name \_\_\_\_\_ Title  Mrs.  Ms.  Dr.  Other \_\_\_\_\_  
Occupation \_\_\_\_\_ Email address \_\_\_\_\_  
Address (*if different*) \_\_\_\_\_  
Cell Phone (*if different*): \_\_\_\_\_ Home 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 from page 1) \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Cell phone \_\_\_\_\_ Home phone \_\_\_\_\_

E-mail 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, mark yes, no, or don't know/understand (dk/u).

## PATIENT HEALTH INFORMATION

Do you take antibiotic pre-medication before any dental procedures?  Yes  No

Does the patient currently have (or ever had) a substance abuse problem? \_\_\_\_\_

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 chew or smoke tobacco? \_\_\_\_\_

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, sensory or developmental issues?

yes  no  dk/u Birth defects or hereditary problems?

yes  no  dk/u Bone fractures, or major injuries?

yes  no  dk/u Any injuries to face, head, 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, sexually transmitted diseases?

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, pneumonia?

yes  no  dk/u Seizures, fainting spells, neurologic problem?

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 common 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, hayfever?

yes  no  dk/u Tonsil 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 intravenous medication for bone disorders or cancer such as bisphosphonates such as Zometa (zoledronic acid), Aredia (pamidronate) or Didronel (etidronate)?

yes  no  dk/u Has your child ever taken oral medication for bone disorders such as bisphosphonates such as Fosamax (alendronate), Actonel (risedronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate)?

## MEDICAL HISTORY *continued*

Has your child had 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 substances \_\_\_\_\_

## DENTAL HISTORY

Now or in the past, has the patient 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 Supernumerary (extra) or congenitally missing teeth?  
 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 broken or missing fillings?  
 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? \_\_\_\_\_

Floss? \_\_\_\_\_

## 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? \_\_\_\_\_

## 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

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 \_\_\_\_\_