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/Province: ____________ Zip Code: ____________

Attends School At: ____________ Grade: ____________

Musical Instrumemts Played: ____________ Sports And/Or Hobbies: ____________

No. of Brothers & Sisters: ________ Ages: ________ Other family members treated here: ____________

Patient's Height ______ ft. ______ in. Birth Father's Height ______ ft. ______ in. Birth Mother's Height ______ ft. ______ in.

Father or Guardian: Mr. ☐ Dr. ☐ ____________ Mother or Guardian: Mrs. ☐ Ms. ☐ Miss. ☐ ____________

Parents: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Is Patient Adopted? ____________

Phone No.(if different than patient's): ____________ Address (if different than patient's)____________

City: ____________ State/Province: ____________ Zip Code: ____________

E-mail address: ____________ Cell phone/pager: ____________

Name Of Patient's Dentist: ____________ Date Last Seen:____________

Name Of Patient's Physician(s): ____________ Date Last Seen: ____________

Who Is Financially Responsible For This Account? Name: ____________

Address (if different than patient's): ____________ Phone No.: ____________

City: ____________ State/Province: ____________ Zip Code:____________

Phone No. (if different than 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 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 treatment 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, tasting or speech difficulties?

☐ Yes ☐ No Loss of weight recently, poor appetite?

☐ Yes ☐ No History of eating disorders (anorexia, bulimia)?

☐ Yes ☐ No Excessive bleeding or bruising tendency, anemia or bleeding disorders?

☐ 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 or throat condition?

☐ Yes ☐ No Hay fever, asthma, sinus trouble or hives?

☐ Yes ☐ No Tonsil or adenoid conditions?

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 currently 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 have 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 in 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 Supernumerary (extra) 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 canals treated?
☐ 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 "Gum boils," 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 ____________________
Other ____________________
☐ Yes ☐ No Tooth grinding or jaw clenching?
☐ 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 also 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 ☐ ☐