

## 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 What sex was the patient a			
What is the patient's current gender identification?	☐ Female ☐ Other		
What are the patient's preferred pronouns?			
Social Security #			
School Grade	Email address(es)		
Home address			
Home phone Cell phone			
PARENT/GUARDIAN			
Custodial parent(s) name(s)			
Patient lives with (check all that apply) Parent 1/Guardian	n Parent 2/Guardian	☐ Parent 3/Guardian	☐ Parent 4/Guardian
Other, if other, what is the relationship?			
Parent 1/Guardian full name			
Occupation	Email address		
Address (if different)			
Cell phone (if different) Hon			
Work phone			
Parent 2/Guardian full name			
Occupation	Email address		
Address (if different)			
Cell phone (if different) Hom			
Work phone			
DENTIST			
Patient's Dentist	Address, City, State		
Last seen	Reason		
Other dentists/dental specialists now being seen: Name		City, State	

#### **GENERAL INFORMATION**

	mu s toour:						
What concerns your child about h	his/her/their t	teeth?					
How does your child feel about o	rthodontic tre	atment?					
Who suggested that your child m	light need ort	hodontic treatme	ent?				
Why did you select our office?							
Describe any previous orthodonti	c treatment o	or consultations.					
Does your child play a musical in	strument?						
Sibling name	age	had orthodontic	treatment?	☐Yes	□ No	If yes, where?	
Sibling name	age	had orthodontic	treatment?	☐ Yes	□ No	If yes, where?	
Sibling name	age	had orthodontic	treatment?	☐ Yes	□No	If yes, where?	
Sibling name	age	had orthodontic	treatment?	☐ Yes	□ No	If yes, where?	
Have any other family members	been treated	in this office? Pl	lease name th	nem			
FINANCIAL RESPONSIB	ILITY						
Who is financially responsible for	this account	?					
Address (if different than page 1)					City, St	ate, Zip	
Cell phone		Home phone			En	nail address(es)	
Social Security #			Employer _				
Who will be responsible for bring	ing the patier	nt to orthodontic	appointment	s?			
DENTAL INSURANCE							
Primary policy holder's full name							Birth date
Social Security #							
				o to patie	nt		
Address and phone (if not listed a	above)		7101010110111	p to patie	nt		
Address and phone (if not listed Employer							
Employer			Address				
EmployerInsurance company			Address				
Employer	benefits?	Yes No	Address Group # Don't Know				
Employer Insurance company Does this policy have orthodontic	benefits?	Yes □ No □	Address Group # ] Don't Know			ID#	Birth date
Employer Insurance company Does this policy have orthodontic Secondary policy holder's full nat	c benefits?	]Yes □ No □	Address Group # ] Don't Know			ID#	
Employer Insurance company  Does this policy have orthodontic Secondary policy holder's full nai Social Security #	benefits?	Yes □ No □	Address Group # ] Don't Know Relationship	p to patie	nt	ID#	Birth date
Employer Insurance company Does this policy have orthodontic Secondary policy holder's full nat Social Security # Address and phone (if not listed Employer	c benefits? [meabove)	Yes □ No □	Address Group # ] Don't Know  Relationship	p to patie	nt	ID#	Birth date
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Employer	above)	Yes No	Address Group # ] Don't Know  Relationship  Address Group # ] Don't Know	p to patie	nt II	ID#	Birth date
Employer	above)	Yes No	Address Group # ] Don't Know  Relationship  Address Group # ] Don't Know	p to patie	nt II	ID#	Birth date

### **PHYSICIAN**

Most recent physical exam	Patie	ent'	s Pi	ysician	City, State					
Moet recent physician physician phasitic care providers being seen now:  Name	Last	see	en_							
Other physicians/health care providers being seen now:  Name	Mos	t re	cent	physical exam						
Name										_
Name									Pageon	
Name										
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/undertastand (dl/u).  PATIENT HEALTH INFORMATION  Does the patient 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/their 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										
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Medication										
Medication					Taken for	_	_	_		_
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Hereditary or developmental conditions?	Yes 1	No [	DK/L	J		Yes	No	DK/I	/U	
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□ Any injuries to face, head, neck?       □ Heart defects, heart murmur, rheumatic heart disease?         □ Arthritis or joint problems?       □ Angina, arteriosclerosis, stroke or heart attack?         □ Cancer, tumor, radiation treatment or chemotherapy?       □ Skin disorder (other than common acne)?         □ Endocrine or thyroid problems?       □ Does your child eat a well-balanced diet?         □ Diabetes or low sugar?       □ Vision, hearing, or speech problems?         □ Kidney problems?       □ Frequent ear infections, colds, throat infections?         □ Immune system problems?       □ Asthma, sinus problems, hayfever?         □ History of osteoporosis?       □ Tonsil or adenoid condition?         □ Gonorrhea, syphilis, herpes, sexually transmitted diseases?       □ Does your child ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate)?         □ Hepatitis, jaundice, or other liver problems?       □ Has your child ever taken oral medication for bone disorders or cancer such as bisphosphonates such as Fosamax (alendronate), Actonel(ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate)?         □ History of eating disorder (anorexia, bullmia)?	_	_	=						Excessive bleeding or bruising, anemia?	
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History of osteoporosis?  Gonorrhea, syphilis, herpes, sexually transmitted diseases?  AIDS or HIV positive?  Hepatitis, jaundice, or other liver problems?  Pollo, mononucleosis, tuberculosis, pneumonia?  Seizures, fainting spells, neurologic problems?  Mental health disturbance or depression?  History of osteoporosis?  Tonsil or adenoid condition?  Does your child frequently breathe through his/her mouth?  Asy your child ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate)?  Has your child ever taken oral medication for bone disorders or cancer such as bisphosphonates such as Fosamax (alendronate), Actonel(ridendronate), Boniva (ibandronate), Skelld (tiludronate) or Didronel (etidronate)?				Kidney problems?					Frequent ear infections, colds, throat infections?	
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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, bullmia)?				Gonorrhea, syphilis, herpes, sexually transmitted					Does your child frequently breathe through his/her mouth	?
or Didronel (etidronate)?  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, bullimia)?		_	_						Has your child ever taken intravenous bisphosphonates	
By Gur Child ever taken or all medication for bone disorders or cancer such as bisphosphonates such as Fosamax (alendronate), Actonel(ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate)?    History of eating disorder (anorexia, bulimia)?		_								
Seizures, fainting spells, neurologic problems?  Mental health disturbance or depression?  History of eating disorder (anorexia, bulimia)?  Fosamax (alendronate), Actonel(ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate)?	_	_							Has your child ever taken oral medication for bone disord	ers
Seizures, fainting spells, neurologic problems? (ibandronate), Skelld (tiludronate) or Didronel (etidronate)?  Mental health disturbance or depression?  History of eating disorder (anorexia, bulimia)?		7								
☐ ☐ History of eating disorder (anorexia, bulimia)?		_							(ibandronate), Skelid (tiludronate) or Didronel (etidronate)	?
	_	_								
	ם ו	7		Frequent headaches or migraines						

MEDICAL HISTORY continued				
WEDICAL HISTORY continued				Any sensitive or sore teeth?
Has your child had allergies or reactions to any of the following?		_	_	Any lost or broken fillings?
Yes No DK/U		_		Jaw fractures, cysts, infections?
□ □ Local anesthetics (novocaine, lidocaine, xylocaine)				Any teeth treated with root canals or pulpotomies?
☐ ☐ Latex (gloves, balloons)				Frequent canker sores or cold sores?
□ □ Aspirin				History of speech problems or speech therapy?
□ □ Ibuprofen (Motrin, Advil)				Difficulty breathing through nose?
Penicillin				Mouth breathing habit or snoring at night?
Other antibiotics				History of speech problems?
☐ ☐ Metals (jewelry, clothing snaps)	ш	ш	ш	Frequent oral habits (sucking finger, chewing pen, etc)?
Acrylics				Current Yes No Age stopped
☐ ☐ Plant pollens		ш	ш	Frequent habit of tongue thrust?
□ □ Animals				Current Yes No Age stopped
□ □ Foods		ш	ш	Frequent habit of fingernall biting?
= = =				Current Yes No Age stopped
□ □ Other substances	П	Ш	Ш	Frecuent habit of lip sucking?
DENTAL HISTORY	_			Current Yes No Age stopped
				Teeth causing irritation to lip, cheek or gums?
Now or in the past, has your child had:			_	Tooth grinding or clenching?
Yes No DK/U			_	Clicking, locking in jaw joints?
□ □ Erupting teeth very early or very late?				
□ □ Primary (baby) teeth removed that were not loose?				Has your child been treated for "TMJ" or "TMD" problems?
□ □ Permanent or extra (supernumerary) teeth removed?				Any broken or missing fillings?
□ □ Supernumerary (extra) or congenitally missing teeth?		Ш	Ш	Any serious trouble associated with previous dental treatment?
□ □ Chipped or injured primary or permanent teeth?				Has your child ever been diagnosed with gum disease or
How often does your child brush? Floss?				pyorrhea?
		_		pyormea?
FAMILY MEDICAL HISTORY  Have the parents or siblings ever had any of the following health problem.				pyormea?
FAMILY MEDICAL HISTORY  Have the parents or siblings ever had any of the following health proble Bleeding disorders Diabetes	ems? If s	so, p	leas	e explainArthritis
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