

## Patient under age 18 Dental/Medical History Form

Date: \_\_\_\_\_

Patient Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Nickname \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Best Contact Number \_\_\_\_\_ Alternate Phone Numbers \_\_\_\_\_

Patient Address – Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient S.S.N./S.I.N. \_\_\_\_\_ Email \_\_\_\_\_

Parent(s) / Guardian(s) Names \_\_\_\_\_ S.S.N. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number(s) \_\_\_\_\_

Responsible Financial Party (if different from above) \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

Name of Patient's Dentist \_\_\_\_\_

Dentist's Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Name of Physician \_\_\_\_\_

Physician Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Patient's School \_\_\_\_\_

Brother(s)/Sister(s) & Age \_\_\_\_\_

Favorite Sports, Hobbies, Avocations \_\_\_\_\_

Insurance Coverage  Yes  No

Primary Insurance Coverage \_\_\_\_\_ Policy Number \_\_\_\_\_

Secondary Insurance Coverage \_\_\_\_\_ Policy Number \_\_\_\_\_

In case we cannot reach you:

Person to contact \_\_\_\_\_ Phone Number \_\_\_\_\_

For the following questions please circle yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

- yes no dk/u Does patient follow directions?
- yes no dk/u Does patient brush his/her teeth conscientiously?
- yes no dk/u Does patient have learning disabilities or need extra help with instructions?
- yes no dk/u Is patient sensitive, self-conscious?

## MEDICAL HISTORY

- |   |  |
|---|--|
| <p>yes no dk/u Bone fractures, any major accidents?<br/>         yes no dk/u Rheumatoid or arthritic conditions?<br/>         yes no dk/u Fainting spells, seizures, epilepsy or neurological problems?<br/>         yes no dk/u Kidney problems?<br/>         yes no dk/u Diabetes?<br/>         yes no dk/u Polio, mono, tuberculosis, pneumonia?<br/>         yes no dk/u Mental health or behavioral problem?<br/>         yes no dk/u Vision, hearing, tasting, or speech difficulties?<br/>         yes no dk/u Loss of weight recently, poor appetite?<br/>         yes no dk/u Excessive bleeding, black and blue tendency, anemia or bleeding disorders?<br/>         yes no dk/u Frequent headaches, colds, sore throats?<br/>         yes no dk/u Cardiovascular problem _____<br/>         yes no dk/u Tonsil or adenoid conditions?<br/>         yes no dk/u Is the patient taking medications?<br/>         Please name them: _____<br/>         _____<br/>         yes no dk/u Hospitalized for _____<br/>         yes no dk/u Being treated by another health care professional?<br/>         For _____<br/>         Date of most recent physical exam? _____</p> | <p>yes no dk/u Problems with immune system?<br/>         yes no dk/u AIDS or HIV positive?<br/>         yes no dk/u Hepatitis, jaundice, or liver problems?<br/>         yes no dk/u Endocrine or thyroid problems?<br/>         yes no dk/u Cancer or been treated for a tumor?<br/>         yes no dk/u Birth defects or hereditary problems?<br/>         yes no dk/u Operations? Surgical Procedures?<br/>         yes no dk/u Skin Disorder?<br/>         yes no dk/u Tires easily?<br/>         yes no dk/u Do you have a normal or good diet?<br/>         yes no dk/u High or low blood pressure?<br/>         yes no dk/u Eye, ear, nose, throat condition?<br/>         yes no dk/u Hayfever, asthma, sinus trouble?<br/>         yes no dk/u Allergies or drug reactions?<br/>         yes no dk/u Does the patient currently have or ever had a substance abuse problem?<br/>         yes no dk/u Other physical problems or symptoms?</p> |
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## DENTAL HISTORY

- |  |  |
|--|--|
| <p>yes no dk/u Primary (baby) teeth removed that were note loose?<br/>         yes no dk/u Permanent or "extra" (supernumerary) teeth removed?<br/>         yes no dk/u Any relative with any similar tooth or jaw relationships?<br/>         yes no dk/u Supernumerary or congenitally missing teeth?<br/>         yes no dk/u Teeth sensitive to hot or cold; teeth throb or ache?<br/>         yes no dk/u Bleeding gums, bad taste, mouth odor?<br/>         yes no dk/u Mouth breathing habit, snoring, difficulty in breathing?<br/>         yes no dk/u Thumb, finger sucking habit? Until _____<br/>         yes no dk/u Tooth grinding, jaw clenching, clicking, locking?<br/>         yes no dk/u Does the patient experience any pain, Or soreness in the muscles of the face, Or around the ears?<br/>         yes no dk/u Difficulty encountered in chewing or jaw opening?<br/>         yes no dk/u Aware of loose, broken or missing restorations (fillings)?<br/>         yes no dk/u Concerned about spaced, crooked, protruding teeth?<br/>         yes no dk/u Aware or concerned about under or over developed jaw?<br/>         yes no dk/u Onset of puberty? Date _____<br/>         yes no dk/u Has patient ever had a prior orthodontic examination or treatment?<br/>         yes no dk/u Has patient recently been under another dentist's care?<br/>         Specialist _____<br/>         Other _____<br/>         Date of most recent dental examination _____</p> | <p>yes no dk/u Teeth come-in very early or late?<br/>         yes no dk/u Jaw fractures, cysts, mouth infections?<br/>         yes no dk/u "Dead Teeth", root canals treated?<br/>         yes no dk/u Periodontal "Gum Problems?"<br/>         yes no dk/u Food impaction between teeth?<br/>         yes no dk/u "Gum Boils," frequent canker sores, cold sore?<br/>         yes no dk/u History of speech problems?<br/>         yes no dk/u Any pain in jaw, ringing in the ears?<br/>         yes no dk/u Abnormal swallowing habit (tongue thrusting)?<br/>         yes no dk/u Any teeth irritating cheek, lip, tongue palate?<br/>         yes no dk/u Any wisdom tooth problems?<br/>         yes no dk/u Has patient ever had periodontal (gum) treatment?<br/>         yes no dk/u Would patient object to wearing orthodontic appliances (braces) should they be indicated?<br/>         How often does patient brush Teeth _____<br/>         Floss _____</p> |
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What is the patient's (or parent's) primary dental concern?  
 \_\_\_\_\_

Realizing that successful treatment greatly depends upon the complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment?  
 \_\_\_\_\_

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

\_\_\_\_\_  
 Signature of patient/parent or guardian

\_\_\_\_\_  
 Date