Medical/Dental History Form
For Patients Under 18 Years of Age

Date _____

Patient's Full Name _____ Nickname _____

Date of Birth _____ Sex _____

Address (street) _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ E-mail _____

Father's Name _____ Occupation _____

Employed By _____ Business Phone _____

Mother's Name _____ Occupation _____

Employed By _____ Business Phone _____

Parents' Marital Status: Married ___ Divorced ___ Separated ___ Widowed ___ Single ___

Person Assuming Financial Responsibility for Orthodontic Treatment _____

Address (if different from above) _____

Whom may we thank for referring you to our office? _____

Patient's Current Dentist _____

Patient's Attitude Toward Orthodontic Treatment: Favorable ___ Indifferent ___ Negative ___

Name and Ages of Patient's Siblings: Brothers _____ Sisters _____

Patient's Hobbies or Interests _____

Do you have Orthodontic Insurance? Yes ___ No ___ If Yes, please complete the information below

Insurance Provider _____ Phone _____

Address _____

Member Name _____ SSN _____

Policy Holder's Date of Birth _____

→

For the following questions 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.

MEDICAL HISTORY

Yes No Dk/u Is patient sensitive, self conscious?
Yes No Dk/u Does patient have learning disabilities?
Yes No Dk/u Vision, hearing tasting or speech difficulties?
Yes No Dk/u Mental health or behavioral problem?
Yes No Dk/u Loss of weight recently, poor appetite?
Yes No Dk/u Excessive bleeding, black & blue tendency, anemia or bleeding disorder?
Yes No Dk/u High or low blood pressure?
Yes No Dk/u Cardiovascular problem (heart trouble) heart defect, coronary insufficiency?
Yes No Dk/u Skin Disorder?
Yes No Dk/u Hayfever, asthma or sinus trouble?
Yes No Dk/u Tonsil or adenoid conditions?
Yes No Dk/u Rheumatoid or arthritic conditions?
Yes No Dk/u Endocrine or thyroid problems?
Yes No Dk/u Diabetes?
Yes No Dk/u Stomach ulcer or hyperacidity?
Yes No Dk/u Fainting spells, seizures, epilepsy or Neurological problem?

Yes No Dk/u Frequent headaches, colds or sore throats?
Yes No Dk/u Allergic to latex?
Yes No Dk/u Allergies or drug reactions? _____

Yes No Dk/u Are you taking medication, nutrient supplements or non-prescription medicine? Please name them. _____
Yes No Dk/u Jaw fractures or any major accidents?
Yes No Dk/u Hospitalized for? _____
Yes No Dk/u Being treated by another health care professional for? _____
Date of most recent exam? _____
Yes No Dk/u Any medical concerns we should be aware of? _____

DENTAL HISTORY

Yes No Dk/u Is child taking any forms of fluoride?
Yes No Dk/u Frequent canker sores or cold sores?
Yes No Dk/u Periodontal "Gum Problems"?
Yes No Dk/u Supernumerary (extra) or congenitally missing teeth?
Yes No Dk/u Mouth breathing habit, snoring or difficulty in breathing?
Yes No Dk/u Tooth grinding, jaw clenching, clicking or locking?
Yes No Dk/u Any pain in jaw or ringing in the ears?
Yes No Dk/u Pain or soreness in the muscles of the face, or around the ears?
Yes No Dk/u Difficulty encountered in chewing or jaw opening?
Yes No Dk/u Concerned about spaced, crooked, protruding teeth?
Yes No Dk/u Aware or concerned about under or over developed jaw?

Yes No Dk/u Any relative with similar tooth or jaw relationships?
Yes No Dk/u Has patient had any serious trouble associated with any previous dental treatment?
Yes No Dk/u Has patient ever had a prior orthodontic examination or treatment?
Yes No Dk/u Has patient recently been under another dentist's care? Specialist _____
Yes No Dk/u Would patient object to wearing orthodontic appliances (braces) should they be indicated?
Yes No Dk/u Date of most recent dental exam?
Yes No Dk/u How often does patient brush? _____
Yes No Dk/u What is patient's (or parents) primary concern? Why are you here? _____

_____

Realizing that successful treatment greatly depends upon the patient's 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 his staff responsible for any errors or omissions that I have made in completing this form. I will inform this practice of any changes.

_____ _____
Signature of patient/ parent or guardian Date