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:_____ Gender: Male☐ Female ☐ Preferred Name:_____
Home Phone No.:_____ Cell No.:_____
Patient's Address:_____ E-mail Address:_____
City:_____ State:_____ Zip Code:_____
Patient Attends School At:_____ Grade:_____
Musical Instruments:_____ Sports & Hobbies:_____
No. of Brothers & Sisters:_____ Ages:_____ Other Family Members Treated Here:_____

Parent: Mr☐Mrs☐Ms☐Dr☐_____ Parent: Mr☐ Mrs☐ Ms☐ Dr☐_____
Legal Guardian: Mr☐ Mrs☐ Ms☐ Dr☐_____
Parents: Single☐Married☐Separated☐Divorced☐Widowed☐ Is the Patient Adopted? Yes☐ No☐
Home Phone No. (if different from patient's):_____Cell No.:_____
Address (if different from patient's):_____ E-mail Address:_____
City:_____ State:_____ Zip Code:_____

Who is Financially Responsible for this Patient? Name:_____
Address (if different from patient's):_____ Phone No. (if different from patient's):_____
City:_____ State:_____ Zip Code:_____

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.:_____

Name of Patient's Dentist:_____ Date Last Seen:_____
Name of Patient's Physician:_____ Date Last Seen:_____
Who suggested that you might need orthodontic treatment?_____ Referred By:_____
What is your primary concern?_____

PATIENT PROFILE

☐Yes ☐No Does patient follow directions well?
☐Yes ☐No Does the patient have a learning disability or need extra help with instructions?
☐Yes ☐No Is the patient sensitive or self-conscious about teeth?
☐Yes ☐No Does patient brush teeth well?
How often does your child brush? _____ Floss? _____

MEDICAL HISTORY

Now or in the past has the patient had:

☐Yes ☐No Birth defects or hereditary problems?
☐Yes ☐No Bone fractures or 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 or pneumonia?
☐Yes ☐No Problems of the immune system?
☐Yes ☐No AIDS or HIV Positive?
☐Yes ☐No Hepatitis, jaundice or liver problems?
☐Yes ☐No Fainting, seizures, epilepsy or neurological problems?
☐Yes ☐No Mental health disturbance or depression?
☐Yes ☐No Vision, hearing, testing or speech difficulties?
☐Yes ☐No Loss of weight recently or poor appetite?
☐Yes ☐No History of eating disorders (anorexia or 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 condition?
☐Yes ☐No Substance abuse problem?
☐Yes ☐No Chew or smoke tobacco?
☐Yes ☐No Is the patient taking any medications, nutrient supplements, herbal medications or non-prescription medicine? Please list.

Medication: _____Taken for:_____
Medication: _____Taken for:_____
Medication: _____Taken for:_____

Allergies or reactions to any of the following:

☐Yes ☐No Local anesthetics (Novocaine or Lidocaine)
☐Yes ☐No Medications (specify) _____
☐Yes ☐No Metals (Jewelry)
☐Yes ☐No Latex (Gloves)
☐Yes ☐No Vinyl
☐Yes ☐No Acrylic
☐Yes ☐No Foods (specify)_____
☐Yes ☐No Other Substances (specify)_____

☐Yes ☐No Operations? Describe: _____

☐Yes ☐No Hospitalizations? Describe: _____

☐Yes ☐No Other physical problems or symptoms? Describe: _____

☐Yes ☐No Being treated by another health care professional?
For:_____

Are there any other medical conditions that we should know about?

_____

_____

GIRLS ONLY

☐Yes ☐No Has the patient started her 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?

_____

_____

_____

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 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 Extra (supernumerary) 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 canal treated teeth?

☐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 Concern about spaces, crooked or protruding teeth?

☐Yes ☐No Concern about under or over developed jaw?

☐Yes ☐No 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 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 Prior orthodontic examination or treatment?

☐Yes ☐No Treatment by another dental specialist?
Specialist:_____

☐Yes ☐No Tooth grinding or jaw clenching habit?

☐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 questions on this form and I have answered accurately and truthfully. I will not hold my orthodontist or any other staff member responsible for any errors or omissions that I have made in completing this form. If there are any changes to my medical/dental status, I will 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 □

TREATMENT

Phase 1 Active Lim Tx

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 □

Missing: _____/_____

Crossbite: /

Letters	□ Referral	□ Diagnostic	□ Contract	□ Completion