



**Medical Dental History Form
For Patients Under Age 18**

PATIENT

Date _____
Patient's Last Name _____ First Name _____ Middle Initial _____
I prefer to be called _____ Date of Birth _____ Age _____ Sex: Male Female
Home Address _____ City, State, Zip code _____
School _____ Grade _____
Hobbies, activities _____

PARENT/GUARDIAN

Father's full name _____ Date of Birth _____
Address (if different than patient address) _____
Social security # _____ Employer _____ Occupation _____
Cell phone () _____ - _____ Home phone () _____ - _____ Work phone () _____ - _____

Mother's full name _____ Date of Birth _____
Address (if different than patient address) _____
Social security # _____ Employer _____ Occupation _____
Cell phone () _____ - _____ Home phone () _____ - _____ Work phone () _____ - _____

EMAIL ADDRESS (of person responsible for appointments) _____

Patient's Dentist _____ Address, City, State _____
Patient's Physician _____ Address, City, State _____

DENTAL INSURANCE

Primary policy holder's full name _____ Date of Birth _____
Social security # _____ Relationship to patient _____
Insurance Company _____ Address _____
Group # _____ ID# _____ Employer _____

Secondary policy holder's full name _____ Date of Birth _____
Social security # _____ Relationship to patient _____
Insurance Company _____ Address _____
Group # _____ ID# _____ Employer _____

GENERAL INFORMATION

What concerns you about your child's teeth? _____
Who referred you to our office? _____
Names and ages of other children in the family _____
Has your child ever had orthodontic treatment? _____

MEDICAL HEALTH INFORMATION

List any medication, nutritional supplements, herbal medications or non-prescription medicines that your child takes _____

Is your child allergic to any food, medicine, other? What? _____

Is your child adopted? Yes No Was your child premature? Yes No If yes, how many weeks? _____

Has any member of the family had a problem with general anesthetic? Yes No

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, please mark yes, no, or don't know/understand (dk/u).

MEDICAL HISTORY

Now or in the past, have you had:

Yes No DK/U

- AIDS or HIV positive?
- Birth defects or hereditary problems?
- Bone fractures or major injuries?
- Any injuries to face, head, neck?
- Arthritis or joint problems?
- Endocrine or thyroid problems?
- Diabetes or low sugar?
- Kidney problems?
- Seizures, fainting spells, neurologic problems?
- Cancer, tumor, radiation treatment?
- Chemotherapy?
- Vision, hearing, or speech problems?
- Stomach ulcer, hyperacidity, acid reflux?
- Immune system problems?
- History of eating disorder (anorexia, bulimia)?
- History of osteoporosis?
- High or low blood pressure?
- Excessive bleeding or bruising, anemia?
- Heart defects, heart murmur?
- Frequent headaches or migraines?
- Frequent ear infections, colds, throat infections?
- Asthma, sinus problems, hay fever?
- Hepatitis, jaundice, or other liver
- Tonsils or adenoids removed?

DENTAL HISTORY

Now or in the past, have you had:

Yes No DK/U

- Permanent or extra teeth removed?
- Extra or congenitally missing teeth?
- Chipped or injured teeth?
- Any sensitive or sore teeth?
- Bleeding gums, bad taste or odor?
- Jaw fractures, cysts, infections?
- Snoring at night?
- Thumb/finger sucking?
- Tongue thrust?
- Tooth grinding or clenching?
- Clicking, locking in jaw joints?
- Soreness in jaw or face muscles?
- Ringing in ears?
- Difficulty in chewing?
- Difficulty in opening jaw?
- Treated for "TMJ" or "TMD"?
- Do you frequently breathe through your mouth?
- Any serious trouble associated with previous dental treatment?

RELEASE AND WAIVER

I authorize release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company.

Parent/Guardian Signature: _____ Date: _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my child's medical or dental health. I give the doctor permission to use such measures as deemed necessary in her professional judgment to render a diagnosis for my child. This would include an oral examination, radiographs, and other diagnostic aids. I have received a copy of this office's Notice of Privacy Practices.

Parent/Guardian Signature: _____ Date: _____