

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	assigned on their birth certificate?	
What is the patient's current gender identification? $\ \ \square$ Male	☐ Female ☐ Other	
What are the patient's preferred pronouns?	-	
Social Security #		
School Grade	Email address(es)	
Home address	City, State, Zip code	
Home phone Cell phone		
PARENT/GUARDIAN		
Custodial parent(s) name(s)		
Patient lives with (check all that apply)	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) Hor	ne phone	
Work phone		
Parent 2/Guardian full name		
Occupation	Email address	
Address (if different)		
	ne phone	
Work phone		
DENTIST		
Patient's Dentist	Address, City, State	
Last seen	Reason	Next appointment
Other dentists/dental specialists now being seen: Name	City, State	
Reason		

GENERAL INFORMATION

What concerns you about your	child's teeth?					
What concerns your child about	his/her/their teeth?					
How does your child feel about						
Who suggested that your child i	might need orthodontic trea	tment?				
Why did you select our office?_						
Describe any previous orthodon						
Does your child play a musical i	nstrument?					
Sibling name	age had orthodor	ntic treatment?	□Yes	□No	If yes, where?	
Sibling name	_ age had orthodor	ntic treatment?	□Yes	□No	If yes, where?	
Sibling name	age had orthodor	ntic treatment?	□Yes	□No	If yes, where?	
Sibling name	age had orthodor	ntic treatment?	□Yes	□No	If yes, where?	
Have any other family members	s been treated in this office	? Please name t	hem			
FINANCIAL RESPONSIE	BILITY					
Who is financially responsible for	or this account?					
Address (if different than page 1) _					ate, Zip	
Cell phone	Home pho	ne		En	nail address(es)	
Social Security #		Employer				
Who will be responsible for bring	ging the patient to orthodor	ntic appointment	ts?			
DENTAL INSURANCE Primary policy holder's full name						Birth date
Social Security #						
Address and phone (if not listed						
Employer						
Insurance company					ID#	
Does this policy have orthodonti						5
Secondary policy holder's full na						Birth date
Social Security # Address and phone (if not listed			p to patier	ıı		
	above)	Address	- 100 E	Mark.		
Employer					.	
Insurance company				IL	D#	
Does this policy have orthodontic	benefits? Tes Tino	□ Don t Know				
MEDICAL INSURANCE						
Policy holder's full name						
Insurance Company						

PHYSICIAN

Patier	nt's F	Physician	City, State				
Last s	een_		Reason			Ne	ext appointment
Most	rece	nt physical exam				Manual desirence and the second	
Other	phys	sicians/health care providers being seen now:					
		City, State				Reason	
		City, State					
Name		City, State				Reason	
Your a	answ	vers are for office records only and are confidential.	A thorough med	dical	his	tory is essential to a complete orth	odontic evaluation. For the
		questions, mark yes, no, or don't know/undertastand					
PAT	IEN	T HEALTH INFORMATION					
		patient take antibiotic pre-medication before any de					
		patient currently have (or ever had) a substance abu					
Do yo	u thi	ink that any of your child's activities affect his/her/tl	neir face, teeth	or ja	ws?	? How?	
List ar	ny m	edication, nutritional supplements, herbal medication	s or non-prescri	iption	n me	edicines, including fluoride supplem	ents that your child takes.
Medic	atio	n	Taken for				
Medic	ation	n	Taken for				
		n					
		child chew or smoke tobacco?					
Have	you i	noticed any unusual changes in your child's face or j	aws?		7.56		
Any o	ther	physical problems?					
MED	OICA	AL HISTORY					
Now	or ir	n the past, has your child had:					
Yes N	• DK	(4)	Ye	s No	n DK	(/II	
						High or low blood pressure?	
	_					Excessive bleeding or bruising, an	nemia?
						Chest pain, shortness of breath,	
		Any injuries to face, head, neck?			_	Heart defects, heart murmur, rhe	
						☐ Angina, arteriosclerosis, stroke o	
	1 [Cancer, tumor, radiation treatment or chemotherap	N2 🗆			Skin disorder (other than commo	
	1 6	Endocrine or thyroid problems?	,,			Does your child eat a well-balance	
	, ,	그 그 그 그 이 아이를 하는 것이 그 얼마나 하는 것이 없는데 그런				☐ Vision, hearing, or speech proble	
	, ,	Diabetes or low sugar? Kidney problems?		-	1 [Frequent ear infections, colds, th	
	, ,				1 [Asthma, sinus problems, hayfeve	
	, ,	Immune system problems?			1 [☐ Tonsil or adenoid condition?	
		History of osteoporosis? Gonorrhea, syphilis, herpes, sexually transmitted] [Does your child frequently breath	e through his/her mouth?
	, _	diseases?				Has your child ever taken intraver such as Zometa (zolendromic aci	nous bisphosphonates
						or Didronel (etidronate)?	-// (parmaroridae)
						Has your child ever taken oral me	
						or cancer such as bisphosphonat Fosamax (alendronate), Actonel(r	ridendronate), Boniva
		Seizures, fainting spells, neurologic problems?				(ibandronate), Skelid (tiludronate)	
		Mental health disturbance or depression?					
		History of eating disorder (anorexia, bulimia)?					
		Frequent headaches or migraines					

Other family medical conditions? 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	Has your child had allergies or reactions to any of the following?				
Yes No DK/U Cacel anesthetics (novocaine, lidocaine, xylocaine) General Service Social Social Service Socia		П			
Latex (gloves, balloons) Frequent canker sores or cold sores? Latex (gloves, balloons) History of speech problems or soech therapy? Mouth breathing through nose? Indicatly breathing through nose? Mouth breathing through nose? Indicatly breathing through nose? Mouth breathing through of speech problems? Mouth breathing through nose? Mouth premiable through nose?	That your offine flee divisions to diff of the following.				
Latex (glows, balloons)	Yes No DK/U				
Aspirin Difficulty treathing through nose?	☐ ☐ Local anesthetics (novocaine, lidocaine, xylocaine)				
	☐ ☐ Latex (gloves, balloons)				
Penicillin History of speech problems? Prequent roal habits sucking finger, chewing pen, etc? Prequent roal habits sucking finger, chewing pen, etc? Prequent roal habits sucking finger, chewing pen, etc? Prequent habit of tongue thrust? Prequent habit of tongue thrust? Prequent habit of fingernali biting? Prepare habits of fingernali biting? Prepa	□ □ Aspirin				Difficulty breathing through nose?
Other antibiotics Frequent oral habits (sucking finger, chewing pen, etc)? Acrylics Acrylics Plant pollens Prequent habit of fongue thrust? Plant pollens Prequent habit of fongue thrust? Prequent habit of fongue thrust? Prequent habit of fongue thrust? Prequent habit of fingeral bilbing?	☐ ☐ Ibuprofen (Motrin, Advil)				Mouth breathing habit or snoring at night?
Metals (jewelry, clothing snaps)	□ □ Penicillin				
Acrylics Plent pollens Frequent habit of torgue brust? Current Yes No Age stopped Frequent habit of fingemail biting? Goods Goods Goods Goods Goods Goods Goods	☐ ☐ Other antibiotics				Frequent oral habits (sucking finger, chewing pen, etc)?
Plant pollens	☐ ☐ Metals (jewelry, clothing snaps)				
Animals Frequent habit of fingermal biting? Courent Yes No Age stopped	□ □ Acrylics				Frequent habit of tongue thrust?
Grods Current Yes No Age stopped Current Yes No Age stopped Current Yes No Age stopped Current Yes No No Age stopped Current Yes	□ □ Plant pollens				Current Yes No Age stopped
DENTAL HISTORY	□ □ Animals				Frequent habit of fingernail biting?
Current _ Yes _ No Age stopped _ Teeth causing irritation to lip, cheek or gums? Cilcking, locking in jaw joints? Cilcking, locking in jaw joints? Soreness in jaw muscles or face muscles? Heavy curled the teeth certain the control of th	□ □ Foods				Current Yes No Age stopped
Current	□ □ Other substances				Frecuent habit of lip sucking?
Now or in the past, has your child had:					Current Yes No Age stopped
Now or in the past, has your child had: Gothing Induity or clenching?	DENTAL HISTORY				Teeth causing irritation to lip, cheek or gums?
Yes No DK/U	Now or in the past, has your child had:				
					보는 것 그렇게 구매했다면 그리고 있다면 모든 사람들이 없는 사람들이 사용하게 되었다면 하는데 되었다면 하는데 되었다.
Primary (baby) teeth removed that were not loose? Has your child been treated for "TMJ" or "TMD" problem Primary (baby) teeth removed that were not loose? Any broken or missing fillings? Any broken or					이 가는 아니다 나는 사람들이 가득하는 것 같아요. 그렇게 되었다면 하는 것이 없는 것이 없는 것이 없는 것이 없는 것이 없는 것이 없는 것이 없다면
Permanent or extra (supernumerary) teeth removed? Any broken or missing fillings? Any serious trouble associated with previous dental treatment? Any serious trouble associated with previous dental treatment or pyorrhea? As your child ever been diagnosed with gum disease or pyorrhea? Any serious trouble associated with previous dental treatment? Any serious trouble associated with previous dental dental desease or pyorrhea? Any serious trouble associated with previous dental desease or pyorrhea? Any serious trouble associated with previous dental disease or pyorrhea? Any serious trouble associated with previous dental desease or pyorrhea? Any serious trouble associated with previous dental desease or pyorrhea? Any serious trouble associated with previous dental desease or pyorrhea? Any serious trouble associated with previous dental desease or pyorrhea? Any serious trouble associated with previous dental desease or pyorrhea? Any serious trouble associated with previous dental desease or pyorrhea? Any serious trouble associated with previous dental desease or pyorrhea? Any serious trouble associated with previous dental desease or pyorrhea? Any serious trouble associated with previous dental desease or pyorrhea? Any serious trouble associated with previous dental desease or pyorrhea? Any serious trouble associated with previous dental p		_			
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Chipped or injured primary or permanent teeth?		_			하는 사람들은 사람들이 사용하다면 가장이 가지 않는 사람들이 가장이 되었다. 그리고 그 아니는 그리고 그리고 그리고 그리고 그리고 그리고 그리고 있다.
How often does your child brush? Floss? Floss? FAMILY MEDICAL HISTORY Have the parents or siblings ever had any of the following health problems? If so, please explain					treatment?
FAMILY MEDICAL HISTORY Have the parents or siblings ever had any of the following health problems? If so, please explain	Chipped or injured primary or permanent teetn?				
Severe allergies					
Other family medical conditions? 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	Have the parents or siblings ever had any of the following health proble	ms? If s	o, pl	lease	e explain.
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	Have the parents or siblings ever had any of the following health proble Bleeding disorders Diabetes	1 6			e explainArthritis
MEDICAL HISTORY UPDATES OR CHANGES Changes	Have the parents or siblings ever had any of the following health proble Bleeding disorders Diabetes Severe allergies Unusual dental problematics.	1 6			e explainArthritis
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Parent/Guardian Signature Date Dental Staff Signature Date Changes Date Parent/Guardian Signature Date Dental Staff Signature Date Changes Date Parent/Guardian Signature Date	Have the parents or siblings ever had any of the following health problet Bleeding disorders Diabetes Diabetes Other family medical conditions? Unusual dental problem family medical conditions? Diabetes Unusual dental problem family medical conditions? Unusual dental problem family medical conditions? Problem family medical conditions? Diabetes Unusual dental problem family medical conditions? Diabetes Diabetes Unusual dental problem family medical conditions? Diabetes	c treatm	s	to m	e explainArthritis Jaw size imbalance ny dental and/or medical insurance company. Date or any member of his/her staff responsible for any errors st of any changes in my child's medical or dental health.
Dental Staff Signature Date Changes Parent/Guardian Signature Date Dental Staff Signature Date Changes Parent/Guardian Signature Date	Have the parents or siblings ever had any of the following health problet Bleeding disorders	c treatm	s	to m	e explainArthritis Jaw size imbalance ny dental and/or medical insurance company. Date or any member of his/her staff responsible for any errors st of any changes in my child's medical or dental health.
Changes	Have the parents or siblings ever had any of the following health problet Bleeding disorders Diabetes Severe allergies Unusual dental protection of the family medical conditions? Unusual dental protection of the family medical conditions? Unusual dental protection of the family medical conditions? RELEASE AND WAIVER I authorize release of any information regarding my child's orthodontion parent/Guardian Signature In the completion of this form. I will not provide the protection of this form. I will not parent/Guardian Signature MEDICAL HISTORY UPDATES OR CHANGES Changes	c treatm	s	to m	e explainArthritis
Parent/Guardian Signature Date	Have the parents or siblings ever had any of the following health problet Bleeding disorders	c treatm	nent odon	to m	e explainArthritis
Dental Staff Signature Date Changes Date Parent/Guardian Signature Date	Have the parents or siblings ever had any of the following health problet Bleeding disorders	c treatm	nent odon	to m	e explain Arthritis Jaw size imbalance ny dental and/or medical insurance company. Date
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	Have the parents or siblings ever had any of the following health probles Bleeding disorders Diabetes Other family medical conditions? Unusual dental problem of the family medical conditions? Parent/Guardian Signature In a completion of this form. I will not for omissions that I have made in the completion of this form. I will not parent/Guardian Signature Parent/Gua	c treatm	s dent	to m	e explainArthritis