**WELCOME TO OUR OFFICE**

MEDICAL & DENTAL HISTORY FORM

Date: Click here to enter text.

**PATIENT INFORMATION**:

Last Name: Click here to enter text. First Name: Click here to enter text. Middle Initial: Click here to enter text.

Prefers to be called: Click here to enter text. Hobbies: Click here to enter text.

Birth Date: Sex: Male ☐ Female ☐ Social Security #: Click here to enter text.

School: Click here to enter text. Grade: Click here to enter text.

Email Address: Click here to enter text.

Home Address: Click here to enter text. City, State, Zip Code: Click here to enter text.

Home Phone: Click here to enter text. Cell Phone: Click here to enter text.

**How did you hear about our practice?** Click here to enter text.

**RESPONSIBLE PARTY INFORMATION:**

Last Name: Click here to enter text. First Name: Click here to enter text. Middle Initial: Click here to enter text.

Mailing Address: Click here to enter text. City, State, Zip Code: Click here to enter text.

Home Phone: Click here to enter text. Work Phone: Click here to enter text.

Cell Phone: Click here to enter text. Alternate Phone: Click here to enter text.

Social Security #: Click here to enter text. Birth Date: Click here to enter text.

Relationship to Patient: Click here to enter text. Employer: Click here to enter text.

Spouse’s Name: Click here to enter text. Relationship to Patient: Click here to enter text.

Spouse’s Employer: Click here to enter text. Occupation: Click here to enter text.

Spouse’s Soc. Sec. #: Click here to enter text. Spouse’s Birth Date: Click here to enter text.

**PARENT/GUARDIAN INFORMATION:**

Custodial parent(s) name(s):Click here to enter text.

Patient lives with (check all that apply): ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandparent(s) ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION:**

Insured Name: Click here to enter text. D.O.B.:Click here to enter text. Soc. Sec. #: Click here to enter text.

Insurance Co.: Click here to enter text. Group #: Click here to enter text. Subscriber ID: Click here to enter text.

Insurance Co. Address: Click here to enter text.

Do you have dual coverage? ☐ Yes ☐ No If Yes, please continue:

Insured’s Name:Click here to enter text. D.O.B.: Click here to enter text. Soc. Sec. #: Click here to enter text.

Insurance Co.: Click here to enter text. Group #: Click here to enter text. Subscriber ID: Click here to enter text.

Insurance Co. Address: Click here to enter text.

Insured’s Employer: Click here to enter text.

Signature: Click here to enter text. Date: Click here to enter text.

**EMERGENCY INFORMATION:**

Name of nearest relative not living with you: Click here to enter text.

Complete Address: Click here to enter text.

Phone: Click here to enter text. Relationship to Patient: Click here to enter text.

**DENTIST:**

Patient’s Dentist: Click here to enter text. Address, City, State: Click here to enter text.

Last seen: Click here to enter text. Reason: Click here to enter text. Next Appointment: Click here to enter text.

Other dentists/ specialists now being seen: Name Click here to enter text. City, State Click here to enter text.

Reason: Click here to enter text.

**GENERAL INFORMATION:**

What concerns you about your child’s teeth? Click here to enter text.

What concerns your child about his/her teeth? Click here to enter text.

How does your child feel about orthodontic treatment? Click here to enter text.

Has anyone else in your family had orthodontic treatment? ☐ yes ☐ no If yes, where? Click here to enter text.

**MEDICAL HISTORY:**

**Now or in the past, have you (your child) had:** (u = uncertain)

☐ yes ☐ no ☐ u Birth defects or hereditary problems

☐ yes ☐ no ☐ u Bone fractures or history of osteoporosis

☐ yes ☐ no ☐ u Any injuries to face, head, neck

☐ yes ☐ no ☐ u Arthritis or joint problems

☐ yes ☐ no ☐ u Cancer, tumor, radiation treatment or chemotherapy

☐ yes ☐ no ☐ u Endocrine or thyroid problems

☐ yes ☐ no ☐ u Diabetes or low sugar

☐ yes ☐ no ☐ u Kidney problems

☐ yes ☐ no ☐ u Immune system problems

☐ yes ☐ no ☐ u Gonorrhea, syphilis, herpes, sexually transmitted diseases

☐ yes ☐ no ☐ u AIDS or HIV positive

☐ yes ☐ no ☐ u Hepatitis, jaundice, or other liver problems

☐ yes ☐ no ☐ u Polio, mononucleosis, tuberculosis, pneumonia

☐ yes ☐ no ☐ u Seizures, fainting spells, neurologic problem

☐ yes ☐ no ☐ u Mental health disturbance or depression

☐ yes ☐ no ☐ u History of eating disorder (anorexia, bulimia)

☐ yes ☐ no ☐ u Frequent headaches or migraines

☐ yes ☐ no ☐ u High or low blood pressure

☐ yes ☐ no ☐ u Excessive bleeding or bruising tendency, anemia

☐ yes ☐ no ☐ u Chest pain, shortness of breath, tire easily, swollen ankles, angina, stroke or heart attack

☐ yes ☐ no ☐ u Heart defects, heart murmur, rheumatic heart disease

☐ yes ☐ no ☐ u Skin disorder (other than common acne)

☐ yes ☐ no ☐ u Vision, hearing or speech problems

☐ yes ☐ no ☐ u Frequent ear infections, colds, throat infections

☐ yes ☐ no ☐ u Asthma, sinus problems, hayfever

☐ yes ☐ no ☐ u Tonsil or adenoid condition

☐ yes ☐ no ☐ u Taken IV bisphosphonates such as Xometa, Aredia or Didronel for bone disorders or cancer

☐ yes ☐ no ☐ u Taken oral bisphosphonates such as Fosamax, Actonel, Boniva, Skelid, or Didronel for bone disorders

**Have you (your child) had allergies or reactions to any of the following:**

☐ yes ☐ no ☐ u Local anesthetics (lidocaine, xylocaine)

☐ yes ☐ no ☐ u Latex (gloves, balloons)

☐ yes ☐ no ☐ u Aspirin

☐ yes ☐ no ☐ u Ibuprofen (Motrin, Advil)

☐ yes ☐ no ☐ u Penicillin or other antibiotics

☐ yes ☐ no ☐ u Metals (jewelry, clothing snaps)

☐ yes ☐ no ☐ u Acrylics

☐ yes ☐ no ☐ u Plant pollens

☐ yes ☐ no ☐ u Foods

☐ yes ☐ no ☐ u Animals

☐ yes ☐ no ☐ u Other substances

**DENTAL HISTORY:**

**Now or in the past, have you (your child) had:**

☐ yes ☐ no ☐ u Permanent or extra (supernumerary) teeth removed

☐ yes ☐ no ☐ u Supernumerary (extra) or congenitally missing teeth

☐ yes ☐ no ☐ u Chipped or injured primary or permanent teeth

☐ yes ☐ no ☐ u Any sensitive or sore teeth

☐ yes ☐ no ☐ u Bleeding gums, bad taste or mouth odor

☐ yes ☐ no ☐ u Jaw fractures, cysts, infections

☐ yes ☐ no ☐ u “Gum boils,” frequent canker sores or cold sores

☐ yes ☐ no ☐ u History of speech problems or speech therapy

☐ yes ☐ no ☐ u Difficulty breathing through nose, mouth breathing habit or snoring at night

☐ yes ☐ no ☐ u Food impaction between teeth

☐ yes ☐ no ☐ u Frequent oral habits (sucking finger, chewing pen, etc)

☐ yes ☐ no ☐ u Teeth causing irritation to lip, cheek or gums

☐ yes ☐ no ☐ u Abnormal swallowing (tongue thrust)

☐ yes ☐ no ☐ u Tooth grinding or clenching

☐ yes ☐ no ☐ u Clicking, locking in jaw joints and/or soreness in jaw muscles or face muscles

☐ yes ☐ no ☐ u Ringing in ears, difficulty in chewing or opening jaw

☐ yes ☐ no ☐ u Have you (your child) ever been treated for “TMJ” or “TMD” problems

☐ yes ☐ no ☐ u Any broken or missing fillings

☐ yes ☐ no ☐ u Any serious trouble associated with previous dental treatment

☐ yes ☐ no ☐ u Have you (your child) ever been diagnosed with gum disease

☐ yes ☐ no ☐ u Have you (your child) ever had an orthodontic consultation or treatment before now

**PATIENT HEALTH INFORMATION:**

List any medications, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you take.

Medication: Click here to enter text. Taken for: Click here to enter text.

Medication: Click here to enter text. Taken for: Click here to enter text.

Do you (your child) take antibiotic pre-medication before any dental procedures? ☐ Yes ☐ No

Do you (your child) have or have had a substance abuse problem? ☐ Yes ☐ No

Do you (your child) chew or smoke tobacco? ☐ Yes ☐ No

Have you noticed any changes in your face or jaws? ☐ Yes ☐ No

Any other physical problems? ☐ Yes ☐ No

How often do you (your child) brush? Click here to enter text.

How often do you (your child) floss? Click here to enter text.

**For FEMALES Only (under 18):**

At approximately what age was your first menstrual cycle? Click here to enter text.

**For WOMEN Only:**

Are you pregnant? ☐ Yes ☐ No

Are you trying to become pregnant? ☐ Yes ☐ No

**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 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.**

**Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL HISTORY UPDATES:**

Changes

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Staff Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Changes

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Staff Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Changes

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Staff Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_