

Date _____ **MEDICAL HISTORY FORM – UNDER 18 YEARS of AGE**

Patient's Last Name _____ First _____ Middle _____

Name Patient Prefers to be Called _____ Birthdate _____ Age _____ Sex _____

Patient's Home Address _____ City _____ State _____ Zip Code _____

Patient's E-mail _____ Mother/Father E-mail _____

Would you like to be reminded of appointments through E-mail? Yes No

Mother's Name _____ Social Security # _____

Address _____ City/State/Zip _____

Home Phone _____ Work Phone _____ Cell Phone/Pager _____

Parent is: Single Married Divorced Widowed Separated

Father's Name _____ Social Security # _____

Address _____ City/State/Zip _____

Home Phone _____ Work Phone _____ Cell Phone/Pager _____

Person Responsible for Account _____

Patient's Dentist _____ Address _____ Phone # _____

Patient's Physician _____ Address _____ Phone # _____

Whom may we thank for referring you to us/How did you hear about our office? _____

Other family members seen by us: _____

Names and ages of siblings: _____

Patient's Weight _____ Height _____ Mother's Height _____ Father's Height _____

Favorite Sports, Hobbies, Avocations _____ Musical Instrument played _____

Patient's School _____ Grade _____

Orthodontic Insurance Coverage: Yes No

Primary Insurance Co. _____ Secondary Insurance _____

Name of Insured _____ DOB _____ Name of Insured _____ DOB _____

Policy # _____ Policy # _____

Person to Contact if we can't reach you/ or Emergency _____ Home # _____

Relation _____ Address _____ Work # _____

For the following questions please answer 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 Birth defects or hereditary problems?
- Yes no dk/u Rheumatoid or arthritic conditions?
- Yes no dk/u Kidney problems?
- Yes no dk/u Cancer or cancer treatments?
- Yes no dk/u Polio, mononucleosis?

- Yes no dk/u Bone fractures, any major accidents?
- Yes no dk/u Endocrine or thyroid problems?
- Yes no dk/u Diabetes?
- Yes no dk/u Ulcers, colitis, or hyperacidity?
- Yes no dk/u Tuberculosis, pneumonia?

Yes no dk/u Problems of immune system?
 Yes no dk/u AIDS or HIV positive?
 Yes no dk/u Mental health or behavioral problems?
 Yes no dk/u Loss of weight recently, poor appetite?
 Yes no dk/u High or low blood pressure?
 Yes no dk/u Skin disorder?
 Yes no dk/u Frequent headaches, colds, sore throats?
 Yes no dk/u Chest pain, shortness of breath, or swelling ankles?
 Yes no dk/u Tonsil or adenoid conditions?
 Yes no dk/u Allergies or drug reactions? _____

yes no dk/u Taking prescription or non-prescription medication? _____

Yes no dk/u Drug, alcohol abuse?

Yes no dk/u Is patient in good health? Date of most recent physical exam? _____

Yes no dk/u Hepatitis, jaundice, liver problems?
 Yes no dk/u Sexually transmitted disease?
 Yes no dk/u Vision, hearing, tasting, or speech difficulties?
 Yes no dk/u Anemia, excessive bleeding, bleeding disorder?
 Yes no dk/u Fainting spells, seizures, epilepsy?
 Yes no dk/u Neurological problems?
 Yes no dk/u Eye, ear, nose, throat conditions?
 Yes no dk/u Cardiovascular problems (heart attack, angina, heart murmur, mitral valve prolapse, stroke, heart defects, rheumatic heart, pacemaker?)

yes no dk/u Onset of puberty (approximate date) _____

Yes no dk/u Hospitalized? For _____

yes no dk/u Hay fever, allergies?

Yes no dk/u Being treated by another health care professional? For _____

yes no dk/u (FEMALES) Is the patient pregnant?

DENTAL HISTORY

What are the main concerns that brought you to our office? _____

Yes no dk/u Has Patient been treated with braces before? Orthodontist _____

Yes no dk/u Has Patient had an orthodontic evaluation before? Date _____

Yes no dk/u Chipped or injured permanent teeth?

Yes no dk/u Teeth sensitive to hot or cold?

Yes no dk/u Jaw fractures, cysts, mouth infections?

Yes no dk/u "Dead Teeth", root canals treated?

Yes no dk/u Periodontal "gum problems"?

yes no dk/u Food impaction between teeth?

Yes no dk/u Canker sores, cold sores?

Yes no dk/u Thumb, finger, sucking habit?

Yes no dk/u Abnormal swallowing (tongue thrusting)?

Yes no dk/u Mouth breathing, snoring, difficulty breathing?

Yes no dk/u Teeth grinding, jaw clenching?

Yes no dk/u Head, neck pain?

Yes no dk/u Pain/soreness in muscles of face, or around ears?

Yes no dk/u Clicking, popping, or locking of jaw?

Yes no dk/u Any pain in jaw or ringing in ears?

Yes no dk/u Ever been treated for "TMJ" problems?

Yes no dk/u Difficulty in chewing or jaw opening?

Yes no dk/u History of "extra" teeth or missing teeth?

Yes no dk/u Have any permanent teeth been removed?

Yes no dk/u Any teeth irritating cheek, lip, tongue, or palate?

Yes no dk/u Primary (baby) teeth removed that were not loose?

Yes no dk/u Concerned about spaced, crooked, protruding teeth?

Yes no dk/u Concerned about under or over developed jaw?

Yes no dk/u Any relative with similar tooth or jaw problem?

Yes no dk/u Any wisdom tooth problems?

Yes no dk/u Is patient sensitive or self-conscious about appearance?

Date of last dental examination _____ How often does patient brush _____ How often does patients floss _____

I have read and understand the above questions. 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. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signature of Guardian

Date