American Association of Orthodontists®

My Life. My Smile. My Orthodontist.®

CONFIDENTIAL

# Medical Dental History Form for Patients Under Age 18

*Please fill out ALL questions in black or blue ink PRIOR to your appointment.*
*Incomplete forms may result in rescheduling your appointment.*
*Thank you for your cooperation.*

## Patient

Date _____

Patient's last name _____ First name _____ Middle initial _____

Prefers to be called _____ Hobbies, activities _____

Birth date _____ Sex ☐ Male ☐ Female 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)* ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandparent(s) ☐ Other _____

Father's full name _____ Title: ☐ Mr ☐ Dr ☐ Other _____

Occupation _____ Email address _____

Address *(if different)* _____

Home phone *(If different)* (  ) _____-_____ Cell phone (  ) _____-_____ Work phone (  ) _____-_____

Mother's full name _____ Title: ☐ Mrs ☐ Ms ☐ Dr ☐ Other _____

Occupation _____ Email address _____

Address *(if different)* _____

Home Phone *(If different)* (  ) _____-_____ Cell 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 teeth? _____

How does your child feel about orthodontic treatment? _____

Who suggested that your child might need orthodontic treatment? _____

Why did you select our office? _____

Describe any previous orthodontic treatment or consultations. _____

Does your child play a musical instrument? _____

Brother/sister name _____ age _____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Brother/sister name _____ age _____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Brother/sister name _____ age _____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Brother/sister name _____ age _____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Have any other family members been treated in this office? Please name them. _____

## Financial Responsibility

Who is financially responsible for this account? _____

Address *(if different than page 1)* _____ City, State, Zip _____

Home phone (  ) _____-_____ Cell phone (  ) _____-_____ Email address(es) _____

Social Security # _____ Employer _____

Who will be responsible for bringing the patient to orthodontic appointments? _____

## Dental Insurance

Primary policy holder's full name _____ Birth date _____

Social Security # _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID# _____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

Secondary policy holder's full name _____ Birth date _____

Social Security # _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID# _____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

## Medical Insurance

Policy holder's full name _____

Insurance Company _____

## Physician

Patient's Physician _____ City, State _____

Last seen _____ Reason _____ Next appointment _____

Most recent physical exam _____

Other physicians/health care providers being seen now:

Name _____ City, State _____

Reason _____

Name _____ City, State _____

Reason _____

**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, has your child had:**

Yes No DK/U

- ☐ ☐ ☐ Birth defects or hereditary problems?
- ☐ ☐ ☐ Bone fractures or major injuries?
- ☐ ☐ ☐ Any injuries to face, head, neck?
- ☐ ☐ ☐ Arthritis or joint problems?
- ☐ ☐ ☐ Cancer, tumor, radiation treatment or chemotherapy?
- ☐ ☐ ☐ Endocrine or thyroid problems?
- ☐ ☐ ☐ Diabetes or low sugar?
- ☐ ☐ ☐ Kidney problems?
- ☐ ☐ ☐ Immune system problems?
- ☐ ☐ ☐ History of osteoporosis?
- ☐ ☐ ☐ Gonorrhea, syphilis, herpes, sexually transmitted diseases?
- ☐ ☐ ☐ AIDS or HIV positive?
- ☐ ☐ ☐ Hepatitis, jaundice, or other liver problems?
- ☐ ☐ ☐ Polio, mononucleosis, tuberculosis, pneumonia?
- ☐ ☐ ☐ Seizures, fainting spells, neurologic problems?
- ☐ ☐ ☐ Mental health disturbance or depression?
- ☐ ☐ ☐ History of eating disorder (anorexia, bulimia)?
- ☐ ☐ ☐ Frequent headaches or migraines?
- ☐ ☐ ☐ High or low blood pressure?
- ☐ ☐ ☐ Excessive bleeding or bruising, anemia?
- ☐ ☐ ☐ Chest pain, shortness of breath, tire easily, swollen ankles?
- ☐ ☐ ☐ Heart defects, heart murmur, rheumatic heart disease?
- ☐ ☐ ☐ Angina, arteriosclerosis, stroke or heart attack?
- ☐ ☐ ☐ Skin disorder (other than common acne)?
- ☐ ☐ ☐ Does your child eat a well-balanced diet?
- ☐ ☐ ☐ Vision, hearing, or speech problems?
- ☐ ☐ ☐ Frequent ear infections, colds, throat infections?
- ☐ ☐ ☐ Asthma, sinus problems, hayfever?
- ☐ ☐ ☐ Tonsil or adenoid condition?
- ☐ ☐ ☐ Does your child frequently breathe through his/her mouth?
- ☐ ☐ ☐ Has your child ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?
- ☐ ☐ ☐ Has your child ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel(ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders?

**Has your child had allergies or reactions to any of the following?**

Yes No DK/U

- ☐ ☐ ☐ Local anesthetics (novocaine, lidocaine, xylocaine)
- ☐ ☐ ☐ Latex (gloves, balloons)
- ☐ ☐ ☐ Aspirin
- ☐ ☐ ☐ Ibuprofen (Motrin, Advil)
- ☐ ☐ ☐ Penicillin
- ☐ ☐ ☐ Other antibiotics
- ☐ ☐ ☐ Metals (jewelry, clothing snaps)
- ☐ ☐ ☐ Acrylics
- ☐ ☐ ☐ Plant pollens
- ☐ ☐ ☐ Animals
- ☐ ☐ ☐ Foods
- ☐ ☐ ☐ Other substances _____

# Dental History

**Now or in the past, has your child had:**

Yes No DK/U

- ☐ ☐ ☐ Erupting teeth very early or very late?
- ☐ ☐ ☐ Primary (baby) teeth removed that were not loose?
- ☐ ☐ ☐ Permanent or extra (supernumerary) teeth removed?
- ☐ ☐ ☐ Supernumerary (extra) or congenitally missing teeth?
- ☐ ☐ ☐ Chipped or injured primary or permanent teeth?
- ☐ ☐ ☐ Any sensitive or sore teeth?
- ☐ ☐ ☐ Any lost or broken fillings?
- ☐ ☐ ☐ Jaw fractures, cysts, infections?
- ☐ ☐ ☐ Any teeth treated with root canals or pulpotomies?
- ☐ ☐ ☐ Frequent canker sores or cold sores?
- ☐ ☐ ☐ History of speech problems or speech therapy?
- ☐ ☐ ☐ Difficulty breathing through nose?
- ☐ ☐ ☐ Mouth breathing habit or snoring at night?
- ☐ ☐ ☐ History of speech problems?
- ☐ ☐ ☐ Frequent oral habits (sucking finger, chewing pen, etc)?
- ☐ ☐ ☐ Teeth causing irritation to lip, cheek or gums?
- ☐ ☐ ☐ Tooth grinding or clenching?
- ☐ ☐ ☐ Clicking, locking in jaw joints?
- ☐ ☐ ☐ Soreness in jaw muscles or face muscles?
- ☐ ☐ ☐ Has your child been treated for "TMJ" or "TMD" problems?
- ☐ ☐ ☐ Any broken or missing fillings?
- ☐ ☐ ☐ Any serious trouble associated with previous dental treatment?
- ☐ ☐ ☐ Has your child ever been diagnosed with gum disease or pyorrhea?

## Patient Health Information

Do you think that any of your child's activities affect his/her face, teeth or jaws? How? _____

_____

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

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Does your child take antibiotic pre-medication before any dental procedures? _____

Does your child have (or ever had) a substance abuse problem? _____

Does your child chew or smoke tobacco? _____

Have you noticed any unusual changes in your child's face or jaws? _____

Any other physical problems? _____

## Family Medical History

Have the parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders _____ Diabetes _____

Arthritis _____ Severe allergies _____

Unusual dental problems _____ Jaw size imbalance _____

Other family medical conditions? _____

_____

How often does your child brush? _____ Floss? _____

## 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.***

Parent/Guardian Signature _____ Date _____

## Medical History Updates or Changes

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 _____