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**American Association of Orthodontists®**

# Medical Dental History Form

## CONFIDENTIAL

My Life. My Smile. My Orthodontist®.

## PATIENT

**for Patients Under Age 18**

**\*\*BLUE OR BLACK INK PLS\* \***

###### 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 \_ Home phone (

City, State, Zip code Cell phone (

**PARENT/GUARDIAN**

Custodial parent(s) name(s}\_ \_

\_ \_ \_

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\_ \_ \_ \_

Patient lives with *(check all that apply)* D Mother D Father D Stepmother D Stepfather D Grandparent(s) D 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 D Other Occupation Email address

Address *(if different)*

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

## DENTIST

###### Patient's Dentist \_ Last seen \_

Address, City, State \_ 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

Brother/ sister name age

Brother/ sister name age

Brother/ sister name age

had orthodontic treatment? □Yes □No If yes, where? had orthodontic treatment? □Yes □No If yes, where? had orthodontic treatment? □Yes □No If yes, where? 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 \_ \_ \_

\_ \_ \_ \_

\_ \_ \_ \_

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\_ \_ \_ \_ \_ \_ \_

\_ \_ \_ \_

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

### DENTAL INSURANCE

**Please provide ALL insurance info**

Prima ry policy holder 's full name \_ \_ \_ \_ \_

\_ \_ \_ \_ \_

\_ \_ \_ \_

\_ \_ \_ \_

\_ \_ \_

\_ \_ \_ \_ \_

Birth date \_

Social Security# \_

Relationship to patient \_ \_ \_

\_ \_ \_ \_

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Address and phone (if not listed above) - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

Employer Address \_

Insurance company\_ \_ \_

\_ \_ \_ \_

\_ \_ \_

\_ \_ \_

Group# \_ ID#

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

Secondary policy holder's full name \_ \_

\_ \_ \_ \_

\_ \_ \_

\_ \_ \_ \_

\_ \_ \_

\_ \_ \_ \_ \_ \_ \_ \_ \_

Birth date \_

Social Security# \_

Relat ionship to patient \_ \_ \_

\_ \_ \_ \_

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Address and phone (if not listed above) - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

Employer \_ \_ \_ \_ \_

\_ \_ \_ \_

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Address

Insu rance company\_ \_ \_

\_ \_ \_ \_

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\_ \_ \_

Group# ID#

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

### MEDICAL INSURANCE

Policy holder 's full name Insurance Company - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

### PHYSICIAN

Patient's Physician \_

City, State \_ \_

\_ \_ \_ \_

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\_ \_ \_

\_ \_ \_ \_ \_ \_

Last see\_n \_ \_

\_ \_ \_ \_ \_

\_ \_ \_ \_ \_ \_

Reaso\_n \_ \_ \_

\_ \_ \_ \_ \_

\_ \_ \_

\_ \_ Next appointment \_

Most recent physical exam - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

Other physicians/health care providers being seen now:

Nam\_e \_

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City, State \_ \_ \_ \_

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Nam\_e \_

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City, State \_ \_ \_ \_ \_ \_ \_ \_

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\_ \_ \_ \_

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 (dkju).*

#### MEDICAL HISTORY Has your child had allergies or reactions to any of the following?

**Now or in the past, has your child had:** Yes No DK/ U

Yes No DK/U □ □ □ Local anesthetics (novocaine, lidocaine , xylocaine)

* □ □ Birth defects or hereditary problems? □ □ □ Latex (gloves, balloons)
* □ □ Bone fractures or major injuries? □ □ □ Aspirin
* □ □ Any injuries to face, head, neck? □ □ □ Ibuprofen (Motrin, Advil)
* □ □ Arthritis or joint problems? □ □ □ Penicillin
* □ □ Cancer, tumor, radiation treatment or chemotherapy? □ □ □ Other antibiotics
* □ □ Endocrine or thyroid problems? □ □ □ Metals Ue welry, clothing snaps)
* □ □ Diabetes or low sugar? □ □ □ Acrylics
* □ □ Kidney problems? □ □ □ Plant pollens
* □ □ Immune system problems? □ □ □ Animals
* □ □ History of osteoporosis? □ □ □ Foods
* □ □ Gonorrhea, syphilis, herpes, sexually transmitted diseases? □ □ □ Othe r substances
* □ □ AIDS or HIV positive?
* □ □ Hepatitis , jaundice, or other liver problems? **DENTAL HISTORY**
* □ □ Polio, mononucleosis, tuberculosis, pneumonia? **Now or in the past, has your child had:**
* □ □ Seizures, fainting spells, neurologic problems? Yes No DK/U
* □ □ Mental health disturbance or depression? □ □ □ Erupting teeth very early or very late?
* □ □ History of eating disorder (anorexia, bulimia)? □ □ □ Primary (baby) teeth removed that were not loose?
* □ □ Frequent headaches or migraines? □ □ □ Permanent or extra (supernumerary) teeth removed?
* □ □ High or low blood pressure? □ □ □ Supernumerary (extra) or congenitally missing teeth?
* □ □ Excessive bleeding or bruising, anemia? □ □ □ Chipped or injured primary or permanent teeth?
* □ □ Chest pain, shortness of breath, tire easily, swollen ankles? □ □ □ Any sensitive or sore teeth?
* □ □ Heart defects, heart murmur, rheumatic heart disease? □ □ □ Any lost or broken fillings?
* □ □ Angina, arteriosc lerosis, stroke or heart attack? □ □ □ Jaw fractures , cysts, infections?
* □ □ Skin disorder (other than common acne)? □ □ □ Any teeth treated with root canals or pulpotomies?
* □ □ Does your child eat a well-balanced diet? □ □ □ Frequent canker sores or cold sores?
* □ □ Visi on, hearing, or speech problems? □ □ □ History of speech problems or speech therapy?
* □ □ Frequent ear infections, colds, throat infections? □ □ □ Difficulty breathing through nose?
* □ □ Asthma , sinus problems, hayfever? □ □ □ Mouth breathing habit or snoring at night?
* □ □ Tonsil or adenoid condition? □ □ □ History of speech problems?
* □ □ Does your child frequently breathe through his/ her mouth? □ □ □ Frequent oral habits (sucking finger, chewing pen, etc)?
* □ □ Has your child ever taken intravenous bisphosphonates □ □ □ Teeth causing irritation to lip, cheek or gums?

□ □ □

such as Zometa (zolend romic acid), Aredia (pamidronate) Tooth grind ing or clenching?

or Didronel (etidronate) for bone disorders or cancer?

□ □ □ Clic king, locking in jaw joints?

* □ □ Has your child ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel(ridendronate), Boniva

□ □ □ Soreness in jaw muscles or face muscles?

(ibandronate), Skelid (tiludronate) or Didronel (etidronate) □ □ □ Has your chi ld been treated for "TMJ" or "TMD " problems? for bone disorders? □ □ □ 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-prescript ion medicines, including fluoride supplements that your child takes.

Medication

Taken for \_ \_ \_

\_ \_ \_

\_ \_ \_ \_ \_ \_

\_ \_ \_ \_ \_ \_

\_ \_ \_

\_ \_ \_ \_

Medication Taken for

Medication

Taken for \_ \_ \_

\_ \_ \_

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

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

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Does your child chew or smoke tobacco? - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

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

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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 \_ \_ \_

\_ \_ \_

\_ \_ \_ \_

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Arthritis \_ Unusual dental problems \_

Severe allergies \_ Jaw size imbalance \_

Other family medical conditions? - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

How often does your child brush? \_ Ross\_? \_

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## RELEASE AND WAIVER

##### I authorize release of any Information regarding my ch/Id's orthodontic treatment to my dental and/or med/cal Insurance company.

Parent/ Guardian Signature \_ \_ \_

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\_ \_ \_

\_ \_ \_

\_ Date

##### I have read the above questions and understand them. I w/11 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 w/11 notify my orthodontist of any changes In my child's medical or dental health.***

Parent/ Guardian Signature \_ \_ \_

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\_ \_ \_

\_ Date

## MEDICAL HISTORY UPDATES OR CHANGES

Change\_s \_ \_ \_ \_ \_ \_

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Parent/ Guardian Signature \_

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\_ \_ \_ \_

Date \_

Dental Staff Signature \_

Date \_ \_ \_ \_

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Change\_s \_ \_ \_ \_ \_ \_

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

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Date \_

Dental Staff Signature \_ \_

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Parent/Guardian Signature \_

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Date \_

Dental Staff Signature \_ \_

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Date \_