Dental/Medical Health History Form for Patients Under Age 18 Patient Information

Date ______________

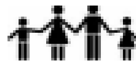
Patient's last name __________________________________ First name___________________________________Middle initial_______

Patient prefers to be called __________________________________ Birth date ___________________ Sex ___ Male ___Female

School________________________________Grade________________ Home address ____

City, State, Zip code ____ Home phone ( ) ________-__________

Cell phone ( ) ________-______ Email Address(es) ____



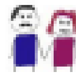
Who is accompanying your child today?

Name: ____Relation:____

Do you have legal custody of this child? ____Yes ____No

List brothers/sisters with age: ____

How did you hear about Classic Orthodontics? ____



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_____________________________________Birthdate______________Email___________________________________

Cell phone #_______________________________ Home phone #__________________________

Address (if different)____Employer________________________________

Occupation_________________________Work phone #________________________

Mother's full name___________________________________Birthdate_______________Email___________________________________

Cell phone #_______________________________ Home phone #__________________________

Address (if different)____Employer__________________________________

Occupation_________________________Work phone #________________________

Dentist

Dentist (First/Last Name) ___________________________________ 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 and what would you like orthodontics to accomplish?

____

How does your child feel about orthodontic treatment?____

Who referred you or suggested that your child might need orthodontic treatment? ____

Why did you select our office? ____

Describe any previous orthodontic treatment or consultations____

Have any other family members been treated in this office? Please name them____

Financial Responsibility

Who is financially responsible for this account? _________________________________Relation_______________________________

Address (if different than page 1) ____ City, State, Zip _________________________

Home phone ( ) _______-_________ Cell phone ( ) _______-_________ Email address(es) _______________________________

Dental Insurance

Primary Insurance

Does this policy have orthodontic benefits? ___Yes ___ No ___ Don't Know

Policy holder's full name ____ Birth date ___________ Social Security #_____________________________________ Relationship to patient ____

Address and phone (if not listed above) ____

Employer ____ Address____

Insurance company________________________ Address_____________________________________ Phone #__________________

Group #(Plan, Local or Policy #) _________________________________ ID#____

Secondary Insurance

Does this policy have orthodontic benefits? ___Yes ___ No ___ Don't Know

Policy holder's full name ____ Birth date ________________ Social Security #_____________________________________ Relationship to patient ____

Address and phone (if not listed above) ____

Employer ____ Address____

Insurance company__________________________Address____________________________________Phone #__________________

Group # (Plan, Local or Policy #)________________________________ ID#____

Medical Physician

Physician ___________________________________ Address, City, State____

Last seen _________________________________ Reason ___________________________________ Next appointment _________

Most recent physical exam ____:

Medical History-

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).

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?

☐ ☐ ☐ Endocrine or thyroid problems?

☐ ☐ ☐ Diabetes or low sugar?

☐ ☐ ☐ Kidney problems?

☐ ☐ ☐ Cancer, tumor, radiation or chemotherapy?

☐ ☐ ☐ Stomach ulcer, hyperacidity, acid reflux?

☐ ☐ ☐ 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?

☐ ☐ ☐ Vision, hearing, or speech problems?

☐ ☐ ☐ History of eating disorder (anorexia, bulimia)?

☐ ☐ ☐ 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)?

☐ ☐ ☐ Frequent headaches or migraines?

☐ ☐ ☐ Frequent ear infections, colds, throat infections?

☐ ☐ ☐ Asthma, sinus problems, hayfever?

☐ ☐ ☐ Tonsil or adenoid condition?

☐ ☐ ☐ Do you frequently breathe through the mouth?

Has your child ever taken intravenous bisphosphonates such as Zometa(zolendromic acid), Aredia(pamidronate) or didronel(etidonate) for bone disorders or cancer? ___Yes ____No ___DK/U

Has your child ever taken oral bisphosophonates such as Fosamax(alendronate), Actonel(ridendronate), Boniva(ibandronate), Skelid(tiludronate) or Didronel(etidronate) for bone disorders? ___Yes ___No ___DK/U

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

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

Dental History

Now or in the past, has the patient had:

Yes No N/A

- ☐ ☐ ☐ Erupting teeth very early or very late?
- ☐ ☐ ☐ Permanent / extra teeth removed?
- ☐ ☐ ☐ Supernumerary or congenitally missing teeth?
- ☐ ☐ ☐ Chipped or injured primary or permanent teeth?
- ☐ ☐ ☐ Any sensitive or sore teeth?
- ☐ ☐ ☐ Bleeding gums, bad taste or mouth odor?
- ☐ ☐ ☐ Jaw fractures, cysts, infections?
- ☐ ☐ ☐ Any teeth treated with root canals or pulpotomies?
- ☐ ☐ ☐ "Gum boils," frequent canker sores or cold sores?
- ☐ ☐ ☐ History of speech problems or speech therapy?
- ☐ ☐ ☐ Soreness in jaw muscles or face muscles?
- ☐ ☐ ☐ Ringing in ears, difficulty chewing or opening jaw?
- ☐ ☐ ☐ Has patient ever been treated for "TMJ" or "TMD"?
- ☐ ☐ ☐ Difficulty breathing through nose?
- ☐ ☐ ☐ Any broken or missing fillings?
- ☐ ☐ ☐ Any trouble with previous dental treatment?
- ☐ ☐ ☐ Has child ever been diagnosed with gum disease?
- ☐ ☐ ☐ Abnormal swallowing (tongue thrust)?
- ☐ ☐ ☐ Tooth grinding or clenching?
- ☐ ☐ ☐ Clicking, locking in jaw joints?
- ☐ ☐ ☐ Teeth causing irritation to lip, cheek or gums?
- ☐ ☐ ☐ Has child ever had an injury to their mouth, teeth, or face?
- ☐ ☐ ☐ Has child ever had an orthodontic consultation or treatment previously?
- ☐ ☐ ☐ Mouth breathing habit or snoring at night?
- ☐ ☐ ☐ Food impaction between the teeth?

____

Y / N: Clenching/Grinding Teeth Y N Nursing Bottle Habits

Y / N: Nail Biting Y N Tongue Thrust

Y / N: Lip Sucking/Biting Y N Speech Problems

Y / N: Mouth Breather Y N Thumb / Finger Sucking

Patient Health Information

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

If Yes, How?_______________________________________

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

Medication ____ Taken for ____________________________________

Medication ____ Taken for ____________________________________

Medication ____ Taken for ____________________________________

Does patient take antibiotic pre-medication before any dental procedures?

____

Does patient currently have or ever had a substance abuse problem?_______________________________________

Does patient chew or smoke tobacco? ____

Have you noticed any changes in patient's face or jaws? ____

List any other physical problems?
____

How often does patient brush? ______________________________

How often does patient 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 _______________