UNDER 18

VERY orthodontics

MEDICAL DENTAL HISTORY FORM
UNDER 18

Date: _____ School: _____

Patient's Name: _____
LAST FIRST MIDDLE

Mailing Address: _____
STREET CITY STATE ZIP

Physical Address: _____
STREET CITY STATE ZIP

Home Phone: _____ Cell Phone: _____ Birth Date: _____ Social Security #: _____

If patient is minor, give parent or guardian's name: _____

Patient Email: _____ Responsible Party Email: _____

Method of appointment reminder: ☐ Email ☐ Text: (_____)_____-_____/carrier: _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Marital Status: _____
LAST FIRST MIDDLE

Residence Address: _____
STREET CITY STATE ZIP

Mailing Address: _____
STREET/P.O. BOX CITY STATE ZIP

How long at this address: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ Alternate Phone: _____

Previous Address *(if less than 3 years)*: _____
STREET CITY STATE ZIP

Social Security #: _____ Birth Date: _____ Relationship to Patient: _____

Employer: _____ No. Years Employed: _____

Occupation: _____ Occupation No. _____
LAST FIRST MIDDLE

Spouse's Name: _____ Relationship to Patient: _____

Spouse's Employer: _____ Occupation No. _____ Years Employed: _____

Spouse's Social Security #: _____ Spouse's Birth Date: _____

INSURANCE INFORMATION

Insured's Name: _____ DOB: _____ Insured's Soc. Sec. #: _____

Insurance Company: _____ Group #: _____ Local No.: _____

Insurance Co. Address: _____

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

Insured's Name: _____ Birth Date: _____ Insured's Soc. Sec. #: _____

Insurance Company: _____ Group #: _____ Local No.: _____

Insurance Co. Address: _____

Insured's Employer: _____

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____

Complete Address: _____

Phone: _____ Relationship to Patient: _____

Signature: _____ Date: _____

For the following questions mark 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.

Now or in the past, have you had:

☐ yes ☐ no ☐ dk/u Birth defects or hereditary problems?
☐ yes ☐ no ☐ dk/u Bone fractures, any major accidents?
☐ yes ☐ no ☐ dk/u Rheumatoid or arthritic conditions?
☐ yes ☐ no ☐ dk/u Endocrine or thyroid problems?
☐ yes ☐ no ☐ dk/u Kidney problems?
☐ yes ☐ no ☐ dk/u Diabetes? If yes, Type I or Type II?
☐ yes ☐ no ☐ dk/u Cancer, tumor, radiation treatment or chemotherapy?
☐ yes ☐ no ☐ dk/u Stomach ulcer or hyperacidity?
☐ yes ☐ no ☐ dk/u Polio, mononucleosis, tuberculosis or pneumonia?
☐ yes ☐ no ☐ dk/u Problems of the immune system?
☐ yes ☐ no ☐ dk/u AIDS or HIV positive?
☐ yes ☐ no ☐ dk/u Hepatitis, jaundice or liver problem?
☐ yes ☐ no ☐ dk/u Fainting spells, seizures, epilepsy or neurological problem?
☐ yes ☐ no ☐ dk/u Mental health disturbance or behavioral problem?
☐ yes ☐ no ☐ dk/u Vision, hearing, tasting or speech difficulties?
☐ yes ☐ no ☐ dk/u Loss of weight recently, poor appetite?
☐ yes ☐ no ☐ dk/u History of eating disorder (anorexia, bulimia)?
☐ yes ☐ no ☐ dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?
☐ yes ☐ no ☐ dk/u High or low blood pressure?
☐ yes ☐ no ☐ dk/u Tires easily?
☐ yes ☐ no ☐ dk/u Chest pain, shortness of breath or swelling ankles?
☐ yes ☐ no ☐ dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
☐ yes ☐ no ☐ dk/u Skin disorder?
☐ yes ☐ no ☐ dk/u Does the patient eat a well-balanced diet?
☐ yes ☐ no ☐ dk/u Frequent headaches, colds or sore throats?
☐ yes ☐ no ☐ dk/u Eye, ear, nose or throat condition?
☐ yes ☐ no ☐ dk/u Tonsil or adenoid conditions?
☐ yes ☐ no ☐ dk/u Hayfever, asthma, sinus trouble?

Allergies or reactions to any of the following:

☐ yes ☐ no ☐ dk/u Latex (gloves, balloons)
☐ yes ☐ no ☐ dk/u Metals (jewelry, clothing snaps)
☐ yes ☐ no ☐ dk/u Local anesthetics, such as Lidocaine
☐ yes ☐ no ☐ dk/u Acrylic
☐ yes ☐ no ☐ dk/u Medications (please specify) _____
☐ yes ☐ no ☐ dk/u Foods (please specify) _____
☐ yes ☐ no ☐ dk/u Other substances (specify)_____
☐ yes ☐ no ☐ dk/u Are you taking medication, nutrient supplements, herbal medications or non-prescription medicine? If yes, please name them:
Medication_____ Taken for _____
Medication_____ Taken for _____
☐ yes ☐ no ☐ dk/u Does the patient currently have or ever had a substance abuse problem?
☐ yes ☐ no ☐ dk/u Does the patient smoke or chew tobacco?
☐ yes ☐ no ☐ dk/u Operations? Describe: _____
☐ yes ☐ no ☐ dk/u Hospitalized? For: _____
☐ yes ☐ no ☐ dk/u Being treated by another health care professional?
If yes, for: _____
☐ yes ☐ no ☐ dk/u Other physical problems or symptoms?
Describe: _____
Are there any other medical conditions (including family medical conditions) that we should be aware of? _____

Who may we thank for referring you to our office:

_____

General Dentist's Name: _____

Now or in the past, have you had:

☐ yes ☐ no ☐ dk/u Started teething very early or late?
☐ yes ☐ no ☐ dk/u Primary (baby) teeth removed that were not loose?
☐ yes ☐ no ☐ dk/u Permanent or "extra" (supernumerary) teeth removed?
☐ yes ☐ no ☐ dk/u Supernumerary (extra) or congenitally missing teeth?
☐ yes ☐ no ☐ dk/u Chipped or otherwise injured primary (baby) or permanent teeth?
☐ yes ☐ no ☐ dk/u Teeth sensitive to hot or cold; teeth throb or ache?
☐ yes ☐ no ☐ dk/u Jaw fractures, cysts or mouth infections?
☐ yes ☐ no ☐ dk/u "Dead teeth" or root canals treated?
☐ yes ☐ no ☐ dk/u Bleeding gums, bad taste or mouth odor?
☐ yes ☐ no ☐ dk/u Periodontal "gum problems"?
☐ yes ☐ no ☐ dk/u Food impaction between teeth?
☐ yes ☐ no ☐ dk/u "Gum Boils", frequent canker sores or cold sores?
☐ yes ☐ no ☐ dk/u Thumb, finger, or sucking habit? Until what age? _____
☐ yes ☐ no ☐ dk/u Abnormal swallowing habit (tongue thrusting)?
☐ yes ☐ no ☐ dk/u History of speech problems?
☐ yes ☐ no ☐ dk/u Mouth breathing habit, snoring or difficulty in breathing?
☐ yes ☐ no ☐ dk/u Tooth grinding, jaw clenching clicking or locking?
☐ yes ☐ no ☐ dk/u Any pain in jaw or ringing in the ears?
☐ yes ☐ no ☐ dk/u Any pain or soreness in the muscles of the face or around the ears?
☐ yes ☐ no ☐ dk/u Difficulty encountered in chewing or jaw opening?
☐ yes ☐ no ☐ dk/u Aware of loose, broken or missing restorations (fillings)?
☐ yes ☐ no ☐ dk/u Any teeth irritating cheek, lip, tongue or palate?
☐ yes ☐ no ☐ dk/u Concerned about spaced, crooked or protruding teeth?
☐ yes ☐ no ☐ dk/u Aware or concerned about under or over developed jaw?
☐ yes ☐ no ☐ dk/u Any relative with similar tooth or jaw relationships?
☐ yes ☐ no ☐ dk/u Any wisdom tooth problems?
☐ yes ☐ no ☐ dk/u Had periodontal (gum) treatment?
☐ yes ☐ no ☐ dk/u Had any serious trouble associated with any previous dental treatment?
☐ yes ☐ no ☐ dk/u Been under another dentist's care?
☐ yes ☐ no ☐ dk/u Been under another dental specialist's care?
☐ yes ☐ no ☐ dk/u Ever had a prior orthodontic examination or treatment?
☐ yes ☐ no ☐ dk/u Would patient object to wearing orthodontic appliances (braces) should they be indicated?

GIRLS ONLY

☐ yes ☐ no ☐ dk/u Has the patient started her monthly periods? If so, approximately when? _____
☐ yes ☐ no ☐ dk/u Are you pregnant?

PATIENT PROFILE

☐ yes ☐ no ☐ dk/u Does patient follow directions well?
☐ yes ☐ no ☐ dk/u Does patient brush his/her teeth conscientiously?
☐ yes ☐ no ☐ dk/u Does patient have learning disabilities or need extra help with instructions?
☐ yes ☐ no ☐ dk/u Is patient self-conscious about teeth?