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MEDICAL DENTAL HISTORY FORM
FOR PATIENTS UNDER 18 YEARS OF AGE

Date _____

Patient's Last Name _____ First _____ Middle _____

Birthdate _____ Age _____ Sex _____ Home Phone No. _____

Patient's Address - Street _____

City _____ State _____ Zip Code _____

Parents Names: Mother _____ Home Phone _____ Business Phone _____

Father _____ Home Phone _____ Business Phone _____

Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

Responsible Party _____ Soc. Sec. # _____

His/Her Address _____ City _____ State _____ Zip _____

Occupation Father _____ Employed By _____

Occupation Mother Employed By _____

Referred by _____

Name of Patient's Dentist _____

Address _____ Phone No. _____

Name of Physician(s) _____

Address _____ Phone No. _____

No. of brothers and sisters Ages _____

Other family members treated _____

Patient's Birth Weight _____ Present Weight _____ Height _____

Father's Height Mother's Height _____

Musical Instrument Played _____

Favorite Sports, Hobbies & Avocations _____

Patient's School _____ Grade _____

Orthodontics Insurance coverage yes ____ no

Primary Insurance Co. _____ Policy No. _____

Secondary Insurance Co. Policy No. _____

In case we cannot reach you:

Person to contact _____ Phone No. _____

If credit arrangements are requested, a credit check may be necessary.

For the following questions circle yes, no, 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.

yes no dk/u Does patient follow directions?
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 sensitive, self, conscious?

MEDICAL HISTORY

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?
yes no dk/u Cancer or been treated for a tumor?
yes no dk/u Stomach ulcer or hyperactivity?
yes no dk/u Polio, mono, tuberculosis, 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 neurologic problem?

yes no dk/u Mental health or behavioral problem?

yes no dk/u Vision, hearing, tasting or speech difficulties?

yes no dk/u Loss or weight recently, poor appetite?

yes no dk/u Excessive bleeding, black and blue 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 or rheumatic heart?**

yes no dk/u Skin disorder?

yes no dk/u Does the patient have a normal diet?

yes no dk/u Frequent headaches, colds or sore throat?

yes no dk/u Eye, ear, nose, throat condition?

yes no dk/u Hayfever, asthma, sinus trouble, hives?

yes no dk/u Tonsil or adenoid conditions?

yes no dk/u Allergies or drug reactions? If yes, explain.

_____

yes no dk/u Is the patient taking medications, nutrient supplements or non prescription medicine? Please name them.

_____

yes no dk/u Does the patient currently have or ever had a substance abuse problem?

yes no dk/u Operations? (surgical procedures)? Explain.

_____

yes no dk/u Hospitalized for _____

yes no dk/u Other physical problems or symptoms? Explain.

_____

yes no dk/u Being treated by another health care professional?

For _____

yes no dk/u Date of most recent physical exam? _____

DENTAL HISTORY

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, mouth infections?

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

yes no dk/u Bleeding gums, bad taste, 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, cold sores?

yes no dk/u Is child taking any forms of fluoride?

yes no dk/u Thumb, finger, sucking habit? Until _____

yes no dk/u Abnormal swallowing habit (tongue thrushing)?

yes no dk/u History of speech problems?

yes no dk/u Mouth breathing habit, snoring, difficulty in breathing?

yes no dk/u Tooth grinding, jaw clenching, clicking, locking?

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

yes no dk/u Does the patient experience any pain or soreness in the muscle 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, palate?

yes no dk/u Concerned about spaced, crooked, 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 Has patient had any serious trouble associated with any previous dental treatment?

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

yes no dk/u Has patient recently been under another dentist's care?

Specialist _____

Other _____

yes no dk/u Has patient ever had periodontal (gum) treatment?

yes no dk/u Would patient object to wearing orthodontic appliances (braces) should they be indicated?

Date of most recent dental examination _____

How often does patient brush _____ floss _____

What is the patient's (or parent's) primary concern? - Why are you here?

_____

Realizing the successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment?

_____

I have read and understand that 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 parent or guardian Date

Medical History Update or Changes: Date: Comments: Signature:

_____

_____

_____

_____

_____

_____

_____