

# MEDICAL DENTAL HISTORY FORM (under age 18)

## PATIENT / CONTACT INFORMATION

Date \_\_\_\_\_

First name \_\_\_\_\_ Last name \_\_\_\_\_ Middle initial \_\_\_\_\_

Prefers to be called \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Birth date \_\_\_\_\_ Age \_\_\_\_\_ Gender  Male  Female  Other ( \_\_\_\_\_ )

Home address \_\_\_\_\_ City, State, Zip code \_\_\_\_\_

Primary phone to call (  Home  Cell  Work ) \_\_\_\_\_ (Name \_\_\_\_\_ )

Secondary phone to call (  Home  Cell  Work ) \_\_\_\_\_ (Name \_\_\_\_\_ )

Primary E-mail address \_\_\_\_\_ (Name \_\_\_\_\_ )

Additional E-mail address \_\_\_\_\_ (Name \_\_\_\_\_ )

Emergency contact (Name) \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

## PARENT / GUARDIAN 1 (Relation to Patient \_\_\_\_\_ )

First and Last Name \_\_\_\_\_ Occupation \_\_\_\_\_

Home address (if different) \_\_\_\_\_ City, State, Zip code \_\_\_\_\_

Work address \_\_\_\_\_ City, State, Zip code \_\_\_\_\_

Primary phone (  Home  Cell  Work ) \_\_\_\_\_ Secondary phone (  Home  Cell  Work ) \_\_\_\_\_

E-mail address (if different from above) \_\_\_\_\_

## PARENT / GUARDIAN 2 (Relation to Patient \_\_\_\_\_ )

First and Last Name \_\_\_\_\_ Occupation \_\_\_\_\_

Home address (if different) \_\_\_\_\_ City, State, Zip code \_\_\_\_\_

Work address \_\_\_\_\_ City, State, Zip code \_\_\_\_\_

Primary phone (  Home  Cell  Work ) \_\_\_\_\_ Secondary phone (  Home  Cell  Work ) \_\_\_\_\_

E-mail address (if different from above) \_\_\_\_\_

**PATIENT LIVES WITH** (check all that apply)  Parent 1/Guardian  Parent 2/Guardian  Other

\*\*If Other, Name, Address and Relationship \_\_\_\_\_

## WHO IS FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT?

Parent 1/Guardian  Parent 2/Guardian  Other (Name and Relationship) \_\_\_\_\_

Responsible Person's: Drivers License \_\_\_\_\_ Social Security Number \_\_\_\_\_

\*\* If Other: Home Address \_\_\_\_\_

Phone \_\_\_\_\_ Email address \_\_\_\_\_

## PRIMARY DENTAL INSURANCE

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

Member's full name \_\_\_\_\_ Birth date \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Social Security Number \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Insurance company \_\_\_\_\_ Group # \_\_\_\_\_ ID# \_\_\_\_\_

## SECONDARY DENTAL INSURANCE

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

Member's full name \_\_\_\_\_ Birth date \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Social Security Number \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Insurance company \_\_\_\_\_ Group # \_\_\_\_\_ ID# \_\_\_\_\_

**PATIENT HEALTH INFORMATION**

Does your child take antibiotic pre-medication before any dental procedures? \_\_Yes \_\_No (Reason \_\_\_\_\_)

List any medication, or non-prescription medicines, including fluoride supplements that your child takes and for what reason:

\_\_\_\_\_

Any serious medical condition, illness, hospitalization, or physical problems? \_\_\_\_\_

\_\_\_\_\_

Does your child have any known allergies? \_\_Yes \_\_No (check all that apply)

\_\_ Latex (gloves, balloons), \_\_ Metals (nickel, jewelry, other), \_\_ Penicillin, \_\_ Amoxicillin, \_\_ Aspirin, \_\_ Ibuprofen (motrin, advil), \_\_ Codiene / Narcotics,

\_\_ Local anesthetics (novocaine, lidocaine, xylocaine), \_\_ Acrylics, \_\_ Other (\_\_\_\_\_)

**DENTAL HISTORY** Please mark Yes, No, or Unknown for each question below. NOW OR IN THE PAST, HAS YOUR CHILD HAD....

Y N ?

- Erupting teeth very early or very late?
- Supernumerary (extra) teeth?
- Congenitally (at birth) missing teeth?
- Primary (baby) teeth removed that were not loose?
- Permanent (adult) teeth removed?
- Any dental implants or fixed bridges?
- Chipped or injured primary or permanent teeth?
- Any sensitive or sore teeth?
- History of speech problems or speech therapy?
- Difficulty breathing through nose
- Mouth breathing habit or snoring at night?
- Tonsils or adenoids removed?
- Teeth grinding or clenching?
- Clicking or popping of the jaw joints (the TMJ)
- Locking of jaws (can't open or can't close jaws)
- Pain associated with opening/closing jaws
- Any treatment for TMJ or TMD problems?

Y N ?

- Frequent canker sores or cold sores?
- Jaw fractures, cysts, infections?
- Injuries to the face or mouth?
- Injures to the teeth?
- Excessive cheek biting?
- Excessive food trapping between teeth?
- Difficulty brushing or flossing?
- Difficulty biting, tearing, or chewing food?
- Still growing in height?
- Still growing in shoe size?
- Has your child reached puberty?
- Girls: Has she started menstruating? (Age \_\_\_\_\_)
- Boys: Has his voice changed? (Age \_\_\_\_\_)
- Does your child grow \_\_slower, \_\_faster or the \_\_same as others?
- Child's height? \_\_\_\_\_
- Father's height? \_\_\_\_\_
- Mother's height? \_\_\_\_\_

**MEDICAL HISTORY** Please mark Yes, No, or Unknown for each question below. NOW OR IN THE PAST, HAS YOUR CHILD HAD....

Y N ?

- Vision or hearing problems?
- Heart murmur?
- Heart defects or other Heart problems?
- Heart surgery, or artificial valve placement?
- Chest pain, heart attack, or stroke?
- High blood pressure?
- Excessive bleeding / bruising, or other blood disorders?
- Anemia?
- Cancer, Radiation or Chemotherapy?
- Hypothyroidism?
- Hyperthyroidism?
- Diabetes?
- Other endocrine problems?
- Hereditary or developmental conditions?
- Immune system problems?
- Frequent ear infections, colds, throat infections?
- Asthma?
- Asthma triggers: \_\_allergies, \_\_smoke/pollution, \_\_weather, \_\_respiratory infections, \_\_physical exercise, \_\_emotional stress
- Sinus problems, hay fever, seasonal allergies?
- Enlarged tonsils or adenoids?
- Lung problems or difficulty breathing?
- Emphysema, bronchitis?

Y N ?

- Polio, mononucleosis, tuberculosis?
- Arthritis or joint problems?
- Skin disorder (other than common acne)?
- Osteoporosis or other bone disorders?
- Intravenous bisphosphonates like Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate)?
- Oral bisphosphonates like Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate)?
- Nervous system problems?
- Seizures or fainting spells?
- Frequent headaches or migraines
- Fibromyalgia?
- Emotional, sensory or developmental issues?
- Mental health problems, anxiety or depression?
- Eating disorder (anorexia, bulimia)?
- Drug or alcohol abuse?
- Fever blisters or Herpes simplex virus?
- AIDS or HIV positive?
- Gonorrhea, syphilis, or other STD?
- Hepatitis, jaundice, or other liver problems?
- Kidney problems?

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**PHYSICIAN**

Patient's Physician \_\_\_\_\_ Phone \_\_\_\_\_ City, State \_\_\_\_\_

Is your child currently under the care of a physician?  Y /  N (Reason \_\_\_\_\_)

Other physicians/health care providers being seen now:

Name \_\_\_\_\_ City, State \_\_\_\_\_ Reason \_\_\_\_\_

Name \_\_\_\_\_ City, State \_\_\_\_\_ Reason \_\_\_\_\_

**DENTIST**

Patient's Dentist \_\_\_\_\_ Dentist Phone \_\_\_\_\_

Address, City, State \_\_\_\_\_ Last Cleaning / Examination \_\_\_\_\_

Other dental specialists being seen: Name \_\_\_\_\_ City, State \_\_\_\_\_

Reason \_\_\_\_\_

**GENERAL INFORMATION**

What concerns you or your child about your child's teeth? \_\_\_\_\_

How does your child feel about orthodontic treatment? \_\_\_\_\_ Wearing braces? \_\_\_\_\_

Who suggested that your child might need orthodontic treatment? \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Was there any previous orthodontic treatment?  Yes  No (When? \_\_\_\_\_ By whom? \_\_\_\_\_)

Was there any previous orthodontic consultation?  Yes  No (When? \_\_\_\_\_ By whom? \_\_\_\_\_)

Have any other family members been treated in this office? Please name them \_\_\_\_\_

Does your child have any oral habits?  Thumb sucking  Chew gum  Bite fingernails  Bite lower lip  Chew ice, pens, straws, other \_\_\_\_\_

Does your child chew / smoke tobacco or vape?  Yes  No (Explain / How often? \_\_\_\_\_)

Please list any sports your child plays \_\_\_\_\_

Please list any musical instruments your child plays \_\_\_\_\_

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

**RELEASE AND WAIVER**

I have read the above questions and understand them. I will not hold Dr. Patrick Lee or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I will notify Dr. Patrick Lee of any changes in my child's medical or dental health. In addition, I authorize release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company

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

Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL HISTORY UPDATES** (Please fill out a new form if changes are significant)

Changes since last time?  Yes  No (Explain \_\_\_\_\_)

Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Changes since last time?  Yes  No (Explain \_\_\_\_\_)

Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Changes since last time?  Yes  No (Explain \_\_\_\_\_)

Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_