

MEDICAL DENTAL HISTORY FORM FOR PATIENTS UNDER 18 YEARS OF AGE

PERSONAL HISTORY

Last Name: _____ First Name: _____ I Prefer to be Called: _____

Birth Date (M/D/Y): _____ Age: _____ Sex: Male Female Phone #: _____

Address: _____

City: _____ Postal Code: _____ Email: _____

Parent(s)/Guardian(s) Name(s): _____ Work #: _____

Other Family Members Treated Here: _____ Cell #: _____

Dentist: _____ Whom May We Thank For Referring you? _____

Who Does This Patient Live with? Mother Father Both Other _____

INSURANCE INFORMATION

Do You Have Insurance Coverage for Orthodontic Treatment? Yes: No: ? Additional Insurance (2)? Y N

Name of Primary Insurance Company:		Employer:		Group/Policy #	
Name of Insured:		Birth Date M/D/Y		ID/Cert. #	

Name of Second Insurance Company:		Employer:		Group/Policy #	
Name of Insured:		Birth Date M/D/Y		ID/Cert. #	

MEDICAL HISTORY:

Name of Patient's Physician: _____ Date Last Seen: _____

Is the patient currently being treated for a medical condition... Y N Please Explain: _____

Has the patient ever been hospitalized.. Y N Please Explain. _____

Has the patient had any operations.. Y N Please List. _____

Physical problems or symptoms we should be aware of..... Y N Please Explain. _____

Has the patient ever had their tonsils/adenoids removed Y N At What Age? _____

Does the patient have any allergies (metals, medications, latex products etc.)..... Y N Please List. _____

NOW OR IN THE PAST HAS THE PATIENT HAD:

Birth defects or hereditary problems..... <input type="checkbox"/> Y <input type="checkbox"/> N	Frequent headaches, colds or sore throats..... <input type="checkbox"/> Y <input type="checkbox"/> N
Excessive bleeding, anemia, or bleeding disorder.... <input type="checkbox"/> Y <input type="checkbox"/> N	Cardiovascular problem, heart murmur or defect ... <input type="checkbox"/> Y <input type="checkbox"/> N
Arthritis..... <input type="checkbox"/> Y <input type="checkbox"/> N	Medication prior to dental treatment..... <input type="checkbox"/> Y <input type="checkbox"/> N
High blood pressure..... <input type="checkbox"/> Y <input type="checkbox"/> N	Accident/injury to the face, mouth or teeth <input type="checkbox"/> Y <input type="checkbox"/> N
Endocrine or thyroid problems..... <input type="checkbox"/> Y <input type="checkbox"/> N	History of an eating disorder (anorexia, bulimia)..... <input type="checkbox"/> Y <input type="checkbox"/> N
Kidney problems..... <input type="checkbox"/> Y <input type="checkbox"/> N	Mental health disturbance or depression..... <input type="checkbox"/> Y <input type="checkbox"/> N
Diabetes..... <input type="checkbox"/> Y <input type="checkbox"/> N	Seizures, epilepsy or neurological problem..... <input type="checkbox"/> Y <input type="checkbox"/> N
Cancer, tumor, radiation or chemotherapy..... <input type="checkbox"/> Y <input type="checkbox"/> N	Taking any medication? (prescription, non-prescription or herbal) <input type="checkbox"/> Y <input type="checkbox"/> N
Pneumonia, tuberculosis or lung disorder..... <input type="checkbox"/> Y <input type="checkbox"/> N	Please List:
HIV positive or AIDS..... <input type="checkbox"/> Y <input type="checkbox"/> N	
Hepatitis, jaundice or liver problem..... <input type="checkbox"/> Y <input type="checkbox"/> N	

DENTAL HISTORY

NOW OR IN THE PAST HAS THE PATIENT HAD:

- Missing or extra permanent teeth? Y N
Jaw clicking, locking or discomfort? Y N
Root canal treated teeth? Y N
Periodontal "gum" problems or treatment? Y N
Abnormal swallowing pattern? Y N
History of speech problems? Y N
Mouth breathing or snoring? Y N
Tooth grinding or jaw clenching? Y N
Frequent canker sores or cold sores? Y N
Prior orthodontic examination(s) or treatment? Y N
Any relative with similar tooth or jaw relationship problems? Y N
Has the patient ever sucked his or her thumb and/or finger? Y N

Until what age? _____

Is there any dental work that still needs to be completed? Y N

Date of Last Check-up? _____

What is your primary orthodontic concern with this patient? _____

List any sports and/or hobbies: _____

List any musical instruments played: _____

Is there anything else we should be aware of to provide optimum orthodontic care for this patient? _____

I have read and understand the above questions. I will not hold my orthodontist or any member of his 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 inform this practice.

Signature: _____ Date: _____

PERSONAL INFORMATION CONSENT:

We are committed to protecting the privacy of our patients' personal information and to utilizing all personal information in a responsible and professional manner. As a requirement of the federal and provincial governing bodies we have privacy policies in place. If you would like further information on the privacy policies of this office please ask one of our staff and we would be happy to answer any questions you may have.

*I consent to the collection, use and disclosure of personal information for _____
(patient name) as set out above.*

Date

Signature of parent/guardian

Print Name