American Association of Orthodontists

MEDICAL DENTAL HISTORY FORM FOR PATIENTS UNDER 18 YEARS OF AGE

CONFIDENTIAL

DATE: ______________

Patient's Last Name:_________________ **First Name:** ________________ **Middle:** ________________

Birth Date:___________ **Age:** ________ **Sex:** **M** **F**

Address: __________________________ **City:** _______________ **State:**________ **Zip Code:**___________

Home Phone: ______________________ **Cell Phone:**_________________________

Email Address: ___________________________________

Name of Parent (s) or Guardian(s): ______________________________________

Alternate Parent Address:___________________ **City:**________________**State:**___ **Zip Code:**__________

Patient's Birth Weight: ______________ **Patient's Present Weight:** ___________ **Height:** _____________

Patient's School: ______________________________ **Musical Instrument Played:**_________________

Favorite Sports, Hobbies, & Avocations: ____

Number of Brother's and Sister's and Names:______________________________ **Ages:** _______________

Other Family Treated Here: ______________________________________

Name of Dentist:__________________________________ **Phone Number:** _________________________

Dentist Address:___________________________ **City:**_________ **State:** _______ **Zip Code:** ___________

Date Last Seen: ____________________________ **Reason:**___________________________

Name of Physician:________________________________

Physician's Address:______________________________ **Phone Number:** ___________________

Date Last Seen: ____________________________ **Reason:**____________________

Who Referred Your Child to Our Office?____

Who is Financially Responsible For This Account? ________________________________

Insurance Coverage for Orthodontic Treatment? **Y** **N**

(TURN OVER TO COMPLETE PAGE 2)

Primary Dental Insurance Company: ___________________ Group ID#:______________________ Plan ID#:________________

Policy Holder's Name: _______________________________ Policy Holder's Employer Name: ____________________________

Policy Holder's DOB: ________/________/_____________ Policy Holder's Social Security #: _______ -_________-________

Secondary Dental Insurance Company: _______________ Group ID#: __________________ Plan ID#: _______________

Policy Holder's Name: ______________________________ Policy Holder's Employer Name:____________________________

Policy Holder's DOB: ______/________/_______________ Policy Holder's Social Security #: ________-_________-________

For the following questions mark yes or no. The answers are for the office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Patient Profile

Yes No Does patient brush his/her teeth conscientiously?
Yes No Does patient have learning disabilities extra help with instructions?

Medical History

Yes No Birth defects or hereditary problems?
Yes No Bone fractures, any major accidents?
Yes No Rheumatoid or arthritic conditions?
Yes No Endocrine or thyroid problems?
Yes No Kidney problems?
Yes No Diabetes?
Yes No Cancer, tumor, radiation treatment or chemotherapy?
Yes No AIDS or HIV positive?
Yes No Hepatitis, jaundice, or liver problems?
Yes No Fainting spells, seizures, epilepsy, or neurological problem?
Yes No Mental health disturbance or depression?
Yes No Vision, hearing, tasting, or speech difficulties?
Yes No History of eating disorders (anorexia, bulimia)?
Yes No Excessive bleeding or bruising tendency, anemia, or bleeding disorder?
Yes No High or low blood pressure?
Yes No Hay fever, asthma, sinus, trouble or hives?
Yes No Tonsil or adenoid conditions?
Yes No Has patient ever been hospitalized?
Yes No **Cardiovascular problem (Heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur, or rheumatic heart disease)?**

Dental History

Yes No Started teething very early or late?
Yes No Chipped or otherwise injured primary (baby) or permanent teeth?
Yes No Teeth sensitive to hot or cold; teeth Throb or ache?
Yes No Jaw fractures, cysts, or mouth infections?
Yes No "Dead teeth" or root canals treated?
Yes No Periodontal "gum problems?"
Yes No Food impaction between teeth?
Yes No Thumb, finger, or sucking habit? Until what age______?
Yes No Abnormal swallowing habit (tongue thrusting)?
Yes No History of speech problem?
Yes No Tooth grinding or jaw clenching?
Yes No Any pain in jaw or ringing in the ears?
Yes No Difficulty encountered in chewing or jaw opening?
Yes No Concerned about spaced, crooked, or protruding teeth?
Yes No Aware or concerned about under or over developed jaw?
Yes No "Gum boils", frequent canker sores, or cold sores?
Yes No Taking any forms of fluoride?
Yes No Any relative with similar tooth or jaw relationships?
Yes No Would you object to wearing orthodontic (braces) should they be indicated?
Yes No Any serious trouble associated with any previous dental treatment?
Yes No Ever had a prior orthodontic examination or treatment?
Yes No Been under dentist's care?
Specialist __________________
Other __________________

Allergies or reaction to any of the following medications:
Aspirin, Ibuprofen, Penicillin, Latex (gloves), Others,
Specify:_____________________________

How often does your child brush: _______ Floss:___
What is your primary concern? Why are you here? ____

I have read and understand the 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 of medical/dental status, I will inform this practice.

Signed:_______________________________________

Date Signed: ________________________________