Members American Association of Orthodontists

Medical Dental History Form
For Patients Under 18

Date: _____

PATIENT

Patient's Last Name: _____ First Name: _____ Middle Initial: _____

Prefers to be called: _____ Hobbies, activities: _____

Birth Date: _____ Age: _____ Sex: Male ☐ Female ☐ S.S.N. /S.I.N.: _____

School: _____ Grade: _____ Email address (es): _____

Home Phone No.: _____ - _____ - _____ Cell phone: _____ - _____ - _____

Home address: _____ City, State, Zip code: _____

PARENT/GUARDIAN

Custodial parent(s) name (s): _____

Patient lives with (check all that apply): ☐ mother ☐ father ☐ stepmother ☐ stepfather ☐ grandparent(s) ☐ other

Father's full name: _____ Title: ☐ Mr. ☐ Dr. ☐ Other: _____

Occupation: _____ Email address: _____

Address (if different): _____

Home Phone (if different): _____ - _____ - _____ Cell Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____

Mother's full name: _____ Title: ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other: _____

Occupation: _____ Email address: _ _____

Address (if different): _____

Home Phone (if different): _____ - _____ - _____ Cell Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____

DENTIST

Name of Patient's Dentist: _____ Address, City, State: _____

Last Seen: _____ Reason: _____ Next Appointment: _____

Other dentists/dental specialists now being seen: Name: _____ City, State: _____

Reason: _____

GENERAL INFORMATION

What concerns you about your child's teeth? _____

What concerns your child about his/her teeth? _____

How does your child feel about orthodontic treatment? _____

Why did you select our office? _____

Describe any previous orthodontic treatment or consultations. _____

Does your child play a musical instrument? _____

Brother/sister name _____ age _____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____
Brother/sister name _____ age _____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____
Brother/sister name _____ age _____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____
Brother/sister name _____ age _____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____
Have any other family members been treated in this office? Please name them: _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____
Address (if different from page 1) _____ City, State, Zip Code: _____
Home Phone (if different): _____ - _____ - _____ Cell Phone: _____ - _____ - _____ Email address (es): _____
Social Security #: _____-_____-_____ Employer: _____
Who will be responsible for bringing the patient to orthodontic appointments? _____

DENTAL INSURANCE

Primary policy holder's full name: _____ Birthdate: _____
Social Security #: _____-_____-_____ Relationship to patient: _____
Address and phone (if not listed above): _____
Employer: _____ Address: _____
Insurance Company: _____ Group #: _____ ID#: _____
Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't know

Secondary policy holder's full name: _____ Birthdate: _____
Social Security #: _____-_____-_____ Relationship to patient: _____
Address and phone (if not listed above): _____
Employer: _____ Address: _____
Insurance Company: _____ Group #: _____ ID#: _____
Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't know

MEDICAL INSURANCE

Policy holder's full name: _____
Insurance Company: _____

PHYSICIAN

Patient's Physician (s): _____ City, State: _____
Last seen: _____ Reason: _____ Next Appointment: _____
Most recent physical exam: _____
Other physicians/health care providers being seen now: _____
Name(s): _____ City, State: _____
Reason: _____

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation. *For the following questions, please mark yes, no, or don't know/understand (dk/u).*

MEDICAL HISTORY

Now or in the past, has your child had:

- ☐ Yes ☐ No ☐ dk/u Birth defects or hereditary problems?
- ☐ Yes ☐ No ☐ dk/u Bone fractures, or major injuries?
- ☐ Yes ☐ No ☐ dk/u Any injuries to face, head, neck?
- ☐ Yes ☐ No ☐ dk/u Arthritis or joint problems?
- ☐ Yes ☐ No ☐ dk/u Cancer, tumor, radiation treatment or chemotherapy?
- ☐ Yes ☐ No ☐ dk/u Endocrine or thyroid problems?
- ☐ Yes ☐ No ☐ dk/u Diabetes or low sugar?
- ☐ Yes ☐ No ☐ dk/u Kidney problems?
- ☐ Yes ☐ No ☐ dk/u Immune system problems?
- ☐ Yes ☐ No ☐ dk/u History of osteoporosis?
- ☐ Yes ☐ No ☐ dk/u Gonorrhea, syphilis, herpes, sexually transmitted diseases?
- ☐ Yes ☐ No ☐ dk/u AIDS or HIV positive?
- ☐ Yes ☐ No ☐ dk/u Hepatitis, jaundice or other liver problems?
- ☐ Yes ☐ No ☐ dk/u Polio, mononucleosis, tuberculosis, pneumonia?
- ☐ Yes ☐ No ☐ dk/u Seizures, fainting spell, neurologic problem?
- ☐ Yes ☐ No ☐ dk/u Mental health disturbance or depression?
- ☐ Yes ☐ No ☐ dk/u History of eating disorder (anorexia, bulimia)?
- ☐ Yes ☐ No ☐ dk/u Frequent headaches or migraines?
- ☐ Yes ☐ No ☐ dk/u High or low blood pressure?
- ☐ Yes ☐ No ☐ dk/u Excessive bleeding or bruising tendency, anemia?
- ☐ Yes ☐ No ☐ dk/u Chest pain, shortness of breath, tire easily, swollen ankles?
- ☐ Yes ☐ No ☐ dk/u Heart defects, heart murmur, rheumatic heart disease?
- ☐ Yes ☐ No ☐ dk/u Angina, arteriosclerosis, stroke or heart attack?
- ☐ Yes ☐ No ☐ dk/u Skin disorder (other than common acne)?
- ☐ Yes ☐ No ☐ dk/u Does your child eat a well-balanced diet?
- ☐ Yes ☐ No ☐ dk/u Vision, hearing, or speech problems?
- ☐ Yes ☐ No ☐ dk/u Frequent ear infections, colds, throat infections?
- ☐ Yes ☐ No ☐ dk/u Asthma, sinus problems, hay fever?
- ☐ Yes ☐ No ☐ dk/u Tonsil or adenoid condition?
- ☐ Yes ☐ No ☐ dk/u Does your child frequently breathe through his/her mouth
- ☐ Yes ☐ No ☐ dk/u Has your child ever taken intravenous Bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?
- ☐ Yes ☐ No ☐ dk/u Has your child ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders?

Has your child had allergies or reactions to any of the following?

- ☐ Yes ☐ No ☐ dk/u Local anesthetics (novocaine, lidocaine)
- ☐ Yes ☐ No ☐ dk/u Latex (gloves, balloons)
- ☐ Yes ☐ No ☐ dk/u Aspirin
- ☐ Yes ☐ No ☐ dk/u Ibuprofen (Motrin, Advil)
- ☐ Yes ☐ No ☐ dk/u Penicillin
- ☐ Yes ☐ No ☐ dk/u Other antibiotics
- ☐ Yes ☐ No ☐ dk/u Metals (jewelry, clothing snaps)
- ☐ Yes ☐ No ☐ dk/u Acrylics
- ☐ Yes ☐ No ☐ dk/u Plant pollens
- ☐ Yes ☐ No ☐ dk/u Animals
- ☐ Yes ☐ No ☐ dk/u Foods
- ☐ Yes ☐ No ☐ dk/u Other substances

Dental History

Now or in the past, has the patient had:

- ☐ Yes ☐ No ☐ dk/u Erupting teeth very early or very 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 injured primary or permanent teeth?
- ☐ Yes ☐ No ☐ dk/u Any lost or broken fillings?
- ☐ Yes ☐ No ☐ dk/u Jaw fractures, cysts or infections?
- ☐ Yes ☐ No ☐ dk/u Any teeth treated with root canals or pulpotomies?
- ☐ Yes ☐ No ☐ dk/u Frequent canker sores or cold sores?
- ☐ Yes ☐ No ☐ dk/u History of speech problems or speech therapy?
- ☐ Yes ☐ No ☐ dk/u Frequent oral habits (sucking finger or chewing pen)
- ☐ Yes ☐ No ☐ dk/u Teeth causing irritation to lip, cheek or gums?
- ☐ Yes ☐ No ☐ dk/u Tooth grinding or clenching?
- ☐ Yes ☐ No ☐ dk/u Clicking, locking in jaw joints?
- ☐ Yes ☐ No ☐ dk/u Soreness in jaw muscles or face muscles?
- ☐ Yes ☐ No ☐ dk/u Has your child been treated for "TMJ" or "TMD" problems?
- ☐ Yes ☐ No ☐ dk/u Any broken or missing fillings?
- ☐ Yes ☐ No ☐ dk/u Any serious trouble associated with previous dental treatment?
- ☐ Yes ☐ No ☐ dk/u Has your child ever been diagnosed with gum disease or pyorrhea?
- ☐ Yes ☐ No ☐ dk/u Difficulty breathing through nose?
- ☐ Yes ☐ No ☐ dk/u Mouth breathing habit or snoring at night?

PATIENT HEALTH INFORMATION

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

List any medications, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that your child takes.

Medication_____Taken for_____
Medication_____Taken for_____
Medication_____Taken for_____
Does the patient currently have (or ever had) a substance abuse problem? _____
Does your child chew or smoke tobacco? _____
Have you noticed any unusual changes in your child's face or jaws? _____
Any other physical problems? _____

FAMILY MEDICAL HISTORY

Have the parents or siblings ever had any of the following health problems? If so, please explain.
Bleeding disorders_____
Diabetes_____
Arthritis_____
Severe allergies_____
Unusual dental problems_____
Jaw size imbalance_____
Other family medical conditions? _____
How often does your child brush? _____
Floss? _____

RELEASE AND WAIVER

I authorize release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company.

Parent/Guardian Signature_____ Date_____

I have read the above questions and understand them. 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. I will notify my orthodontist of any changes in my child's medical or dental health.

Parent/Guardian Signature_____ Date_____