American Association of Orthodontists®

CONFIDENTIAL

Medical Dental History Form for Patients Under Age 18

PATIENT

Date ______

Patient's Last name ______ First name ______ Middle initial ______

Prefers To Be Called ______ Hobbies, activities ______

Birth date ______ Sex: Male ☐ Female ☐

Social Security # - -

School Grade E-mail address(es)

Home address ______ City, State, Zip code ______

Home phone (______)______-______ Cell phone (______)______-______

PARENT/GUARDIAN

Custodial parent(s) name (s) ______

Patient lives with (*check all that apply*) ☐ mother ☐ father ☐ stepmother ☐ stepfather ☐ grandparent(s)
☐ other If other, what is the relationship? ______

Father's full name ______ Title ☐ Mr. ☐ Dr. ☐ Other______

Occupation ______ Email address ______

Address (*if different*) ______

Cell Phone (*if different*): (______)______-______ Home phone (______)______-______

Work phone (______)______-______

Mother's full name ______ Title ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other______

Occupation ______ Email address ______

Address (*if different*) ______

Cell Phone (*if different*): (______)______-______ Home phone (______)______-______

Work phone (______)______-______

DENTIST

Patient's Dentist ______ Address, City, State ______

Last seen ______ Reason ______ Next appointment ______

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

Reason ______

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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? ______

Who suggested that your child might need 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 ______

Cell phone (______) ______ - ______ Home phone (______) ______ - ______

E-mail address(es) ______

Social Security # ______- ______ - ______ Employer______

Who will be responsible for bringing the patient to orthodontic appointments? ______

DENTAL INSURANCE

Primary policy holder's full name ______ Birth date ______

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 ______ Birth date ______

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 ______

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Insurance company ______

PHYSICIAN

Patient's Physician ______ City, State ______

Last seen ______ Reason ______ Next appointment ______ Most recent physical exam ______

Other physicians/health care providers being seen now:

Name ______ City, State ______ Reason ______

Name ______ 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, mark yes, no, or don't know/understand (dk/u).

PATIENT HEALTH INFORMATION

Do you take antibiotic pre-medication before any dental procedures? ☐ Yes ☐ No

Does the patient currently have (or ever had) a substance abuse problem? ______

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

List any medication, 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 your child chew or smoke tobacco? ______

Have you noticed any unusual changes in your child's face or jaws? ______

Any other physical problems? ______

MEDICAL HISTORY

Now or in the past, has your child had:

☐ yes ☐ no ☐ dk/u Emotional, sensory or developmental issues?
☐ 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 spells, 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, hayfever?
☐ yes ☐ no ☐ dk/u Tonsil or adenoids removed?
☐ yes ☐ no ☐ dk/u Does your child frequently breathe through his/her mouth?
☐ yes ☐ no ☐ dk/u Has your child ever taken intravenous medication for bone disorders or cancer such as bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate)?
☐ yes ☐ no ☐ dk/u Has your child ever taken oral medication for bone disorders such as bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) ?

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MEDICAL HISTORY continued

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

☐ yes ☐ no ☐ dk/u Latex (gloves, balloons)
☐ yes ☐ no ☐ dk/u Metals (jewelry, clothing snaps)
☐ yes ☐ no ☐ dk/u Acrylics
☐ yes ☐ no ☐ dk/u Local anesthetics (novocaine, lidocaine, xylocaine)
☐ 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 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 sensitive or sore teeth?
☐ yes ☐ no ☐ dk/u Any lost or broken fillings?
☐ yes ☐ no ☐ dk/u Jaw fractures, cysts, 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 Difficulty breathing through nose?
☐ yes ☐ no ☐ dk/u Mouth breathing habit or snoring at night?
☐ yes ☐ no ☐ dk/u History of speech problems?
☐ yes ☐ no ☐ dk/u Frequent habit of thumb/finger sucking?
Current ___ Yes ___ No Age stopped _____
☐ yes ☐ no ☐ dk/u Frequent habit of tongue thrust?
Current ___ Yes ___ No Age stopped _____
☐ yes ☐ no ☐ dk/u Frequent habit of fingernail biting?
Current ___ Yes ____ No Age stopped _____
☐ yes ☐ no ☐ dk/u Frequent habit of lip sucking?
Current ___ Yes ____ No Age stopped _____
☐ 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?

How often does your child brush? ______

Floss? ______

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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? ______

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_______________

MEDICAL HISTORY UPDATES

Changes ______
Parent/Guardian Signature ____ Date_______________
Dental Staff Signature ____ Date_______________

Changes ______
Parent/Guardian Signature ____ Date_______________
Dental Staff Signature ____ Date_______________

Changes ______
Parent/Guardian Signature ____ Date_______________
Dental Staff Signature ____ Date_______________

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