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YOUTH MEDICAL DENTAL HISTORY FORM

Date:

Patient's Last Name: ______________________________First Name: ____________Middle Name/Initial: _____

Birth Date: _____ Age: _____ Sex: Male Female Prefers To Be Called: ____________S.S.N. ____________

Custodial Parent'(s) or Guardian'(s) Name: Mother: ______________________Father: ____________

Patient's Address: ______________________________

City: ______________State/Province: _____ Postal Code: _____ Home Phone No.: (_____) _____-_____

Patient's E-mail Address:______________________________ Cell phone/pager: (_____) _____-_____

Parent's E-mail Address:______________________________ Cell phone/pager: (_____) _____-_____

Attends School At: ______________ Grade: _____ Musical Instruments Played: ______________

Sports And/Or Hobbies: ______________________________

No. of brothers and sisters: _____Ages: __________ Other family members treated here:______________

Patient's Present Weight _____lbs. Patients Present Height _____ft. _____in.

Additional Address of Parent/Guardian: ______________________________

Additional E-mail Address:______________________________Cell phone/pager: (_____) _____-_____

Preferred method to be notified of future visits: Text Email Preferred method to receive general correspondence: Mail Email

Name of Dentist: ______________________Date Last Seen: __________ Reason: ______________

Dentist's Address: ______________________________

City: ______________________ State/Province: _____ Zip/Postal Code: _____ Phone No.: (_____) _____-_____

Name Of Physician (s): ______________________Date Last Seen: __________ Reason: ______________

Physician's Address: ______________________________

City: ______________________ State/Province: _____ Zip/Postal Code: _____ Phone No.: (_____) _____-_____

Who Is Financially Responsible For This Account? Last Name: ______________ First Name: ______________ MI: _____

Address (if different from patient's): ______________________________ Years at address: _____

If less than five years, previous address: ______________________________

Phone No. (if different than patient's): (_____) _____-_____S.S.N/S.I.N .: ______________

Employer:______________________________ How many years?_____

Insurance Coverage For Dental Treatment? Yes No Insurance Coverage For Orthodontic Treatment? Yes No

Primary Policy Holder's Name: ______________ S.S.N./S.I.N.: ______________ Birth Date:

Employed By: ______________Dental Insurance Company: ______________Group No. _________

Secondary Policy Holder's Name: ______________ S.S.N./S.I.N.: ______________ Birth Date: _______

Employed By: ______________Dental Insurance Company: ______________Group No. _________

Medical Insurance Company:______________________ Group No. ______________

PRIMARY CONCERN

What is your primary concern? Why are you here? ______________________________

____

Who suggested that you might need orthodontic treatment? ______________________________

Why did you select our office? ______________________________

For the following questions mark yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

MEDICAL HISTORY

Now or in the past, has the patient had:

yes no dk/u Birth defects or hereditary problems?
yes no dk/u Bone fractures, any major accidents?
yes no dk/u Rheumatoid or arthritic conditions?
yes no dk/u Endocrine or thyroid problems?
yes no dk/u Kidney problems?
yes no dk/u Diabetes?
yes no dk/u Cancer, tumor, radiation or chemotherapy?
yes no dk/u Stomach ulcer or hyperacidity?
yes no dk/u Polio, mononucleosis, tuberculosis or pneumonia?
yes no dk/u Problems of the immune system?
yes no dk/u AIDS or HIV positive?
yes no dk/u Hepatitis, jaundice or liver problem?
yes no dk/u Fainting spells, seizures, epilepsy or neurological problem?
yes no dk/u Mental health disturbance or behavioral problem?
yes no dk/u Vision, hearing, tasting or speech difficulties?
yes no dk/u Loss of weight recently, poor appetite?
yes no dk/u History of eating disorder (anorexia, bulimia)?
yes no dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?
yes no dk/u High or low blood pressure?
yes no dk/ u Tires easily?
yes no dk/u Chest pain, shortness of breath, swelling ankles?
yes no dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
yes no dk/u Skin disorder?
yes no dk/u Does the patient eat a well-balanced diet?
yes no dk/u Frequent headaches, colds or sore throats?
yes no dk/u Eye, ear, nose or throat condition?
yes no dk/u Hayfever, asthma, sinus trouble or hives?
yes no dk/u Tonsil or adenoid conditions?
yes no dk/u Has/Had the patient a substance abuse problem?
yes no dk/u Does the patient chew or smoke tobacco?
yes no dk/u Operations? Describe: ____________________
yes no dk/u Hospitalized? For: ______________________
yes no dk/u Other physical problems or symptoms?
Describe: ________________________________
yes no dk/ u Being treated by another health care professional? For:
____

Are there any other medical conditions that we should be aware of?

____

GIRLS ONLY

yes no dk/u Has the patient started her monthly periods?
If so, approximately when? _____
yes no dk/u Is the patient pregnant?

PATIENT PROFILE

yes no dk/u Does the patient brush your teeth conscientiously?
yes no dk/u Is she/he sensitive or self-conscious about teeth?

Medication Taken for

Medication Taken for

Medication Taken for

yes no dk/u Is she/he taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.
Date of most recent physical exam? ______________________________

Allergies or reactions to any of the following:

yes no dk/u Local anesthetics (Novocaine or Lidocaine)
yes no dk/u Aspirin
yes no dk/u Ibuprofen (Motrin, Advil)
yes no dk/u Penicillin or other antibiotics
yes no dk/u Sulfa drugs
yes no dk/u Codeine or other narcotics
yes no dk/u Metals (jewelry, clothing snaps)
yes no dk/u Latex (gloves, balloons)
yes no dk/u Vinyl
yes no dk/u Acrylic
yes no dk/u Animals
yes no dk/u Foods (specify) ___________________________
yes no dk/u Other substances (specify) _________________

FAMILY MEDICAL HISTORY

Do the patients parents or siblings have any of the following health problems? If so, please explain.

Bleeding disorders:

Diabetes:

Arthritis:

Metabolic disturbances:

Severe allergies:

Unusual dental problem:

Jaw size imbalance:

Any other family medical conditions that we should know about?

DENTAL HISTORY

Now or in the past, has the patient had:

yes no dk/u Started teething very early or late?

yes no dk/u Primary (baby) teeth removed that were not loose?

yes no dk/u Permanent or "extra" teeth removed?

yes no dk/u Supernumerary/extra or congenitally missing teeth?

yes no dk/u Chipped or otherwise injured primary (baby) or permanent teeth?

yes no dk/u Teeth sensitive to hot or cold; teeth throb or ache?

yes no dk/u Jaw fractures, cysts or mouth infections?

yes no dk/u "Dead teeth" or root canals treated?

yes no dk/u Bleeding gums, bad taste or mouth odor?

yes no dk/u Periodontal "gum problems"?

yes no dk/u Food impaction between teeth?

yes no dk/u Thumb, finger, or sucking habit? Until what age _____

yes no dk/u Abnormal swallowing habit (tongue thrusting)?

yes no dk/u History of speech problems?

yes no dk/u Mouth breathing, snoring or difficulty in breathing?

yes no dk/u Tooth grinding, jaw clenching clicking or locking?

yes no dk/ u Any pain in jaw or ringing in the ears?

yes no dk/u Any pain or soreness in the muscles of the face or around the ears?

yes no dk/u Difficulty encountered in chewing or jaw opening?

yes no dk/u Loose, broken/missing restorations fillings?

yes no dk/u Any teeth irritating cheek, lip, tongue or palate?

yes no dk/u Concerned about spaced, crooked or protruding teeth?

yes no dk/u Aware or concerned about under or over developed jaw?

yes no dk/u "Gum Boils", frequent canker sores or cold sores?

yes no dk/u Taking any forms of fluoride?

yes no dk/u Any relative with similar tooth or jaw relationships?

yes no dk/u Had periodontal (gum) treatment?

yes no dk/u Would patient object to wearing orthodontic appliances (braces) should they be indicated?

yes no dk/u Any serious trouble associated with any previous dental treatment?

yes no dk/u Ever had a prior orthodontic examination or treatment?

yes no dk/u Been under another dentist's care?
Specialist ________________________________
Other ___________________________________

How often does the patient brush? _______________________ Floss? _______________________________

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 or medical/dental status, I will so inform this practice.

Signed: ____ Date Signed: _____________________
(Parent or Guardian)

Signed: ____ Date Signed: _____________________
(Dental Staff Member)