Member American Association of Orthodontists®

CONFIDENTIAL

Medical Dental History Form For Patients Under Age 18 (Child)

Date____/____/_____

Patient's Name_____ Birth Date____/____/____ Age_____ Sex: M F

Home Address_____City_____Zip Code_____

Cell Phone_____ Responsible Party Email_____

Appointments may be verified by text messages to the Responsible Party

Parent/Guardian _____Birth Date____/____/____Marital Status: S M D

Relationship to Patient _____

Employer_____Business Phone_____

Address (if different from patient) _____

Parent/Guardian _____Birth Date____/____/____Marital Status: S M D

Relationship to Patient _____

Employer_____Business Phone_____

Address (if different from patient) _____

Names and ages of children under 18_____

Does patient have insurance coverage for orthodontic treatment? Yes No

Employee Name_____ID#_____SSN#_____Birth Date___/___/____

Insurance Company_____Employer_____ Group #_____

Employee Name_____ID#_____SSN#_____Birth Date___/___/____

Insurance Company_____Employer_____ Group #: _____

Medical/Dental History

Yes No Is patient in good health? (If No – explain on reverse side)
Yes No Is patient physically, mentally, or emotionally impaired? (If Yes – explain on reverse side).
Yes No Is patient or has the patient been under the care of a physician for a major illness? (If Yes – explain on reverse side)
Yes No Is patient taking any medications or drugs? (If Yes – list and explain on reverse side)
Yes No Is premedication (antibiotics) required for dental procedures? (If Yes – explain on reverse side)
Yes No Does patient have any allergies or drug sensitivities including anesthetics, latex, metals etc.? (If Yes – list on reverse side)
Yes No Does patient have any medical history that you feel the orthodontist should be aware of? (If Yes – explain on reverse side)

Has the child had any history of, or conditions related to, any of the following (check only the conditions that apply):

___ Anemia	___ Fainting Spells or Dizziness	___ Endocrine Problems	___ Speech Problems
___ Arthritis	___ Hearing or Vision	___ Liver Problems	___ Injury to Mouth/Teeth
___ Asthma	___ Heart	___ Nervous Disorders	___ Injury to Face
___ Bleeding Disorders	___ Hepatitis	___ Seizures	___ Mental Health Disturbance
___ Bones/Joints	___ HIV or AIDS	___ Tobacco/Drug Use	___ Depression
___ Cancer	___ Hyper/Hypotension	___ Thyroid Problems	___ Periodontal/Gum Disease
___ Diabetes	___ Kidney Problems	___ Tuberculosis	___ Other _____

Yes No Has patient ever sucked a thumb or fingers? Until what age? _____
Yes No Does patient have any speech problems (including tongue thrusting), breathing problems, lip or nail-biting habits?
Yes No Has patient been informed they have or have had periodontal (gum) disease?
Yes No Has patient been informed of any missing or extra permanent teeth?
Yes No Has patient ever been told they have TMJ/TMD problems or been treated for TMJ/TMD or any jaw related problems?
Yes No Has patient ever had any previous orthodontic evaluations or consultations?
Yes No Has patient had any previous orthodontic treatment?

What concerns you about your child's teeth?_____
What concerns your child about their teeth? _____
Why did you select our office? _____
Who suggested your child might need orthodontic treatment? _____
Who referred your child to our office? _____
Who is your dentist? _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of the 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. I authorize release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company.

Parent/Guardian Signature _____ **Date** _____

Medical/Dental History – Explanations:

Is patient in good health? (If No – explain) _____

Is patient physically, mentally, or emotionally impaired? (If Yes – explain) _____

Is patient or has the patient been under the care of a physician for a major illness? (If Yes – explain)

Is patient taking any medications or drugs? (If Yes – list and explain) _____

Is premedication (antibiotics) required for dental procedures? (If Yes – explain) _____

Does the patient have any allergies or drug sensitivities including anesthetics, latex, metals etc.? (If Yes – list) _____

Does the patient have any medical history that you feel the orthodontist should be aware of? (if Yes – explain) _____

Please use the following if additional space is needed:

Medical Dental History Updates or Changes

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** _____