



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
Social Security #
School
Grade
Email 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

General Information

What is your primary concern about your child's teeth?
Is your child on Medicaid?

Please arrange the following in order of importance to you. \*\*( 1 being most important and 5 being your least concern)

Total Cost of Treatment
Monthly Payment
Quality of Treatment
Professionalism of Staff
Advanced Technology

Financial Responsibility

Who is financially responsible for this account?
Address (if different from above)
City, State, Zip
Best phone number to reach
SSN:
Who will be responsible for bringing patient to orthodontic appointments?

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

**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?
- Bone fractures or major injuries?
- Any injuries to face, head, neck?
- Arthritis or joint problems?
- Cancer, tumor, radiation treatment or chemotherapy?
- Endocrine or thyroid problems?
- Diabetes or low sugar?
- Kidney problems?
- Immune system problems?
- History of osteoporosis?
- Gonorrhea, syphilis, herpes, sexually transmitted diseases?
- AIDS or HIV positive?
- Hepatitis, jaundice, or other liver problems?
- Polio, mononucleosis, tuberculosis, pneumonia?
- Seizures, fainting spells, neurologic problems?
- Mental health disturbance or depression?
- History of eating disorder (anorexia, bulimia)?
- Frequent headaches or migraines?
- High or low blood pressure?
- Excessive bleeding or bruising, anemia?
- Chest pain, shortness of breath, tire easily, swollen ankles?
- Heart defects, heart murmur, rheumatic heart disease?
- Angina, arteriosclerosis, stroke or heart attack?
- Skin disorder (other than common acne)?
- Does your child eat a well-balanced diet?
- Vision, hearing, or speech problems?
- Frequent ear infections, colds, throat infections?
- Asthma, sinus problems, hayfever?
- Tonsil or adenoid condition?
- Does your child frequently breathe through his/her mouth?
- Has your child ever taken intravenous bisphosphonates such as Zometa (zoledronic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?
- 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, xylocaine)
- Latex (gloves, balloons)
- Aspirin
- Ibuprofen (Motrin, Advil)
- Penicillin
- Other antibiotics
- Metals (jewelry, clothing snaps)
- Acrylics
- Plant pollens
- Animals
- Foods
- Other substances \_\_\_\_\_

## DENTAL HISTORY

**Now or in the past, has your child had:**

Yes No DK/U

- Erupting teeth very early or very late?
- Primary (baby) teeth removed that were not loose?
- Permanent or extra (supernumerary) teeth removed?
- Supernumerary (extra) or congenitally missing teeth?
- Chipped or injured primary or permanent teeth?
- Any sensitive or sore teeth?
- Any lost or broken fillings?
- Jaw fractures, cysts, infections?
- Any teeth treated with root canals or pulpotomies?
- Frequent canker sores or cold sores?
- History of speech problems or speech therapy?
- Difficulty breathing through nose?
- Mouth breathing habit or snoring at night?
- History of speech problems?
- Frequent oral habits (sucking finger, chewing pen, etc)?
- Teeth causing irritation to lip, cheek or gums?
- Tooth grinding or clenching?
- Clicking, locking in jaw joints?
- Soreness in jaw muscles or face muscles?
- Has your child been treated for "TMJ" or "TMD" problems?
- Any broken or missing fillings?
- Any serious trouble associated with previous dental treatment?
- Has your child ever been diagnosed with gum disease or pyorrhea?

**Please Fill Out the Following Questions With Regard to the Patient Listed Above, Whether You or Your Child:**

**DENTIST**

Are you a patient of Kids First Dental?  Yes  No

If yes, Skip to **PHYSICIAN**. If No, please fill out this section.

Patient's Dentist \_\_\_\_\_ City, State \_\_\_\_\_

Last seen (Month, Year) \_\_\_\_\_ Reason \_\_\_\_\_

Next Appointment (Month, Year) \_\_\_\_\_

Other dentists/dental specialists now being seen:

Name \_\_\_\_\_ City, State \_\_\_\_\_

Reason \_\_\_\_\_

**PHYSICIAN**

Patient's Physician \_\_\_\_\_ City, State \_\_\_\_\_

Last seen (Month, Year) \_\_\_\_\_ Reason \_\_\_\_\_

Other physicians/health care providers being seen now:

Name \_\_\_\_\_ City, State \_\_\_\_\_ Reason \_\_\_\_\_

Name \_\_\_\_\_ City, State \_\_\_\_\_ Reason \_\_\_\_\_

**PATIENT HEALTH INFORMATION**

List any medications, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements you take.

Medication \_\_\_\_\_ Taken for \_\_\_\_\_

Medication \_\_\_\_\_ Taken for \_\_\_\_\_

Medication \_\_\_\_\_ Taken for \_\_\_\_\_

**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 OR CHANGES**

Changes \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Dental Staff Signature \_\_\_\_\_ Date \_\_\_\_\_