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 _____ What sex was the patient assigned on their birth certificate? _____ ☐ Male ☐ Female

What is the patient's current gender identification? ☐ Male ☐ Female ☐ Other

What are the patient's preferred pronouns? _____

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)* ☐ Parent 1/Guardian ☐ Parent 2/Guardian ☐ Parent 3/Guardian ☐ Parent 4/Guardian

☐ Other, if other, what is the relationship? _____

Parent 1/Guardian full name _____

Occupation _____ Email address _____

Address *(if different)* _____

Cell phone *(if different)* _____ Home phone _____

Work phone _____

Parent 2/Guardian full name _____

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 _____

## GENERAL INFORMATION

What concerns you about your child's teeth? _____

What concerns your child about his/her/their 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? _____

Sibling name _____ age _____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Sibling name _____ age _____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Sibling name _____ age _____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Sibling 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 than page 1)* _____ City, State, Zip _____

Cell phone _____ Home 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 _____ 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 _____

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 _____

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/undertastand (dl/u).*

## PATIENT HEALTH INFORMATION

Does the patient 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/their 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? |
| ☐ | ☐ | ☐ | Hereditary or developmental conditions? |
| ☐ | ☐ | ☐ | 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 |

| Yes | No | DK/U | |
|---|---|---|---|
| ☐ | ☐ | ☐ | 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 (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate)? |
| ☐ | ☐ | ☐ | Has your child ever taken oral medication for bone disorders or cancer such as bisphosphonates such as Fosamax (alendronate), Actonel(ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate)? |

## MEDICAL HISTORY continued

**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)?
  Current ___ Yes ___ No Age stopped ___
- ☐ ☐ ☐ Frequent habit of tongue thrust?
  Current ___ Yes ___ No Age stopped ___
- ☐ ☐ ☐ Frequent habit of fingernail biting?
  Current ___ Yes ___ No Age stopped ___
- ☐ ☐ ☐ Frecuent habit of lip sucking?
  Current ___ Yes ___ No Age stopped ___
- ☐ ☐ ☐ 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?

**How often does your child brush?** _____ **Floss?** _____

## 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 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 _____