

New Patient Health History – Under Age 18

PATIENT

Date ___/___/___
 First Name: _____ Last Name: _____ Middle Initial: _____
 Prefers to be called: _____
 Birth date: ___/___/___ Sex: Male Female
 Home address: _____ City, State, Zip code: _____
 Home phone () _____ - _____ Cell phone () _____ - _____ Email address: _____
 School _____ Grade _____
 Hobbies, activities _____

PARENT/GUARDIAN

Custodial parent(s) name(s) _____
 Patient lives with (check all that apply) Mother Father Stepmother Stepfather Grandparent(s) Other _____
 Father's full name _____ Title: Mr. Dr. Other _____
 Occupation _____ Email address _____
 Address (if different) _____
 Home phone (if different) () _____ - _____ Cell phone() _____ - _____ Work phone () _____ - _____
 Mother's full name _____ Title: Mrs. Ms. Dr. Other _____
 Occupation _____ Email address _____
 Address (if different) _____
 Home phone (if different) () _____ - _____ Cell phone() _____ - _____ Work phone () _____ - _____

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? _____
 Please describe any previous orthodontic treatment or consultations _____
 Brother/sister name _____ age _____ had orthodontic treatment? Yes No
 Brother/sister name _____ age _____ had orthodontic treatment? Yes No
 Brother/sister name _____ age _____ had orthodontic treatment? Yes No
 Have any family members been treated in this office? Please name them: _____

DENTIST

Patient's Dentist _____ Address, City, State _____
Last seen _____ Reason _____ Next appointment _____
Other dentists/dental specialists now being seen:
Name _____ City, State _____
Reason _____

PHYSICIAN

Patient's Physician _____ City, State _____
Last seen _____ Reason _____ Next appointment _____
Most recent physical exam _____
Other dentists/dental specialists now being seen:
Name _____ City, State _____
Reason _____
Name _____ City, State _____
Reason _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____
Address (if different from page 1) _____ City, State, Zip _____
Home phone () _____ - _____ Cell phone () _____ - _____ Email addresses _____
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 & phone (if not listed above) _____
Employer Address _____
Insurance company _____ Group # _____ ID# _____
Does this policy have orthodontic benefits? Yes No I don't know

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, have 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?
- Endocrine or thyroid problems?
- Diabetes or low sugar?
- Kidney problems?
- Cancer, tumor, radiation treatment or chemotherapy?
- Stomach ulcer, hyperacidity, acid reflux?
- 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?
- Vision, hearing, or speech problems?
- History of eating disorder (anorexia, bulimia)?
- 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)?
- Frequent headaches or migraines?
- Frequent ear infections, colds, throat infections?
- Asthma, sinus problems, hayfever?
- Tonsil or adenoid condition
- Does your child frequently breathe through the mouth?
- Has your child ever taken intravenous bisphosphonates such as Zometa, Aredia, or Didronel for bone disorders or cancer?
- Has your child ever taken oral bisphosphonates such as Fosamax, Actonel, Boniva, Skelid or Didronel for bone disorders?

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?
- Bleeding gums, bad taste, or mouth odor?
- Jaw fractures, cysts, infections?
- Any teeth treated with root canals or pulpotomies?
- "Gum boils," frequent canker sores or cold sores?
- History of speech problems or speech therapy?
- Difficult breathing through nose?
- Food impactions between the teeth?
- Mouth breathing habit or snoring at night?
- Frequent oral habits (sucking finger, chewing pen, etc)?
- Teeth causing irritation to lip, cheek, or gums?
- Abnormal swallowing (tongue thrust)?
- Tooth grinding or clenching?
- Clicking, locking in jaw joint?
- Soreness in jaw muscles or face muscles?
- Ringing in ears, difficult chewing or opening jaw?
- Have you ever been treated for "TMJ" or "TMD" problems?
- Any broken or missing fillings?
- Any serious trouble with previous dental treatment?
- Ever been diagnosed with gum disease or pyorrhea?
- Have your child ever had any orthodontic consultation or treatment before now?

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

Yes No DK/U

- Local anesthesia (novocaine, lidocaine, xylocaine)
- Latex (gloves, balloons)
- Aspirin
- Metals (jewelry, clothing snaps)
- Pencilin
- Other antibiotics
- Ibuprofen (Motrin, Advil)
- Acrylics
- Plant pollens
- Animals _____
- Foods _____
- Other _____

PATIENT HEALTH INFORMATION

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 take antibiotic pre-medication before any dental procedures? _____

Does your child have (or ever had) a substance abuse problem? _____

Does your child chew or smoke tobacco? _____

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

Any other physical problems? _____

How often does your child brush? _____ How often does your child 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.

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.

Signature _____ Date ___ / ___ / ___