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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 address:

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