

Patient's Family Information, Medical, & Dental History (Child/Young Adult)

(please complete in ink)

Today's Date _____

Patient's Name _____
First Last M.I. Nickname Age Sex Date of Birth

Address _____
Street City Zip Tel. # (____) _____

School _____ Grade _____

Best telephone number to call for appointments (During Business Hours) _____

Mom's Cell # _____ Dad's Cell # _____ Best E-mail Address _____

Father's Name _____
First Last M.I. Father's SS# _____
(for insurance purposes only)

Father's Date of Birth _____ Insurance ID # _____

Father's Marital Status: Single Married Separated Divorced Widowed Remarried Other

Home Address _____
Street City Zip Home Tel.# (____) _____

Employed by _____ Occupation _____ Position _____

Employer Address _____
Street City Zip Work Tel. # (____) _____

Does Father have Orthodontic Insurance? _____ Yes _____ No Name of Insurance Company _____
(This may be different from Dental Insurance)

Does Father have Medical Insurance? _____ Yes _____ No Name of Insurance Company _____

Mother's Name _____
First Last M.I. Mother's SS# _____
(for insurance purposes only)

Mother's Date of Birth _____ Insurance ID # _____

Mother's Marital Status: Single Married Separated Divorced Widowed Remarried Other

Home Address _____
Street City Zip Home Tel.# (____) _____

Employed by _____ Occupation _____ Position _____

Employer Address _____
Street City Zip Work Tel. # (____) _____

Does Mother have Orthodontic Insurance? _____ Yes _____ No Name of Insurance Company _____
(This may be different from Dental Insurance)

Does Mother have Medical Insurance? _____ Yes _____ No Name of Insurance Company _____

Patient's Family Dentist

Name _____ Address _____ Tel. # _____

Patient's Family Physician

Name _____ Address _____ Tel. # _____

Whom may we thank for referring you to our office? _____

If responsible party is other than the patient's parents, please give information: (grandparent or step-parent) Not Applicable

Name _____ S.S.# _____ Relationship to patient _____
(for insurance purposes only)

Insurance ID # _____ Date of Birth _____

Address _____ Tel. # (_____) _____
Street City Zip

Employed by _____

Employer Address _____ Work Tel. # (_____) _____
Street City Zip

Does Responsible Party have Orthodontic Insurance? ____ Yes ____ No Name of Insurance Company _____
(This may be different from Dental Insurance)

Does Responsible Party have Medical Insurance? ____ Yes ____ No Name of Insurance Company _____

MEDICAL HISTORY

Has patient had or does patient have any of the following?

	Yes	No		Yes	No
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Persistent Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pains	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Nerve or Brain Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Migraine or Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Blood Vessel Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Problems	<input type="checkbox"/>	<input type="checkbox"/>
AIDS/HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Bone Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis (Any type)	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (Any type)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Ear Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Herpes (Any type)	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Infection	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Glands	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>

Comments _____

Please list any other significant information about the patient's medical history: _____

- Yes No
- Is patient under a physician's care at present? If yes, reason _____
 - Is patient presently, or has patient ever been, under the care of a psychiatrist or psychologist?
If yes, describe _____
 - Is patient currently taking any medication? If yes, describe _____
 - Is patient allergic to any medications? (Eg: aspirin, penicillin, etc.) If yes, list. _____
 - Has patient ever had any general anesthesia? When & why? _____
 - Does patient take any vitamins? If yes, what type? _____

DENTAL HISTORY

Yes No

Do any teeth hurt? If yes, upper right upper left lower right lower left

Have any wisdom teeth been removed? How many? _____

Has he/she ever had treatment for a periodontal disease (gum disease)? If yes, describe _____

Has he/she ever had any previous orthodontic treatment (braces)? If yes, when _____
If yes, doctor's name and address _____

Have there been any injuries to his/her mouth or teeth? If yes, describe _____

Has he/she ever had any injury to the head or neck area? If yes, describe _____

Has he/she ever fallen and bumped his/her chin, or received any trauma to his/her jaws? If yes, describe _____

Has he/she ever had any surgery in the head and neck area? If yes, describe _____

Does he/she clench or grind his/her teeth? If yes, while sleeping under stress other _____

Do his/her jaw muscles ever feel tired? If yes, when _____

Has he/she ever noticed soreness, tightness or pain in the muscles around the jaws or face? If yes, describe _____

Does it hurt to chew? If yes, where does it hurt? _____

Does he/she hear clicking (popping) or grating sounds in his/her jaw joints? If yes, please describe:

	Right	Left	Since when	During what activity
<input type="checkbox"/> Clicking:	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Grating:	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Did these joint sounds begin gradually or suddenly? gradually suddenly

Was there some specific event that started the joint sound or pain? If yes, describe _____

Has he/she ever experienced difficulty in opening or closing his/her jaws? If yes, describe _____

Have his/her jaws ever "locked" closed? If yes, describe _____

Have his/her jaws ever "locked" wide open? If yes, describe _____

Does he/she have pain in his/her jaw joints? If yes, right left Since when? _____

Did his/her pain start gradually or suddenly? gradually suddenly
During what activity? _____ Describe nature of pain _____
What increases the pain? _____ What decreases the pain? _____

Does the patient have any of the following habits?

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Finger/Thumb sucking	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink soda, coffee, tea? (caffienated beverages)
<input type="checkbox"/>	<input type="checkbox"/>	Lip Biting	<input type="checkbox"/>	<input type="checkbox"/>	Smoke or Smokeless Tobacco User?
<input type="checkbox"/>	<input type="checkbox"/>	Nail Biting			
<input type="checkbox"/>	<input type="checkbox"/>	Gum Chewing			
<input type="checkbox"/>	<input type="checkbox"/>	Ice Chewing			

GROWTH AND DEVELOPMENT

- Yes No
- Has patient reached adolescent growth? _____
- Girls - Has monthly cycle started yet? If so, when _____
- Boys - Has voice changed yet? If so, when _____
- Is the patient adopted? Does the patient know? Yes No
- Are there any learning disabilities? If yes, explain _____
- Are there other children in the family?
Names and ages _____
- Has any other member of the family had orthodontic treatment? _____
- Has any other member of the family been a patient in this office?
Name(s) _____

Please describe why you sought this consultation

- Has patient ever been treated for this problem before? If yes, please describe the diagnosis and treatment _____

Any information you can give us concerning your child will be appreciated. The more we know about each patient, the more help we can give in managing the orthodontic treatment, both at home and in the office. Also, please include special interests and hobbies:

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

(Signature of Responsible Adult)

Date

Doctor's Notes

(Doctor's Signature)

Date