

## 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                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Is patient under a physician's care at present? If yes, reason _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Is patient presently, or has patient ever been, under the care of a psychiatrist or psychologist?<br>If yes, describe _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is patient currently taking any medication? If yes, describe _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Is patient allergic to any medications? (Eg: aspirin, penicillin, etc.) If yes, list. _____                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Has patient ever had any general anesthesia? When & why? _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | 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

- Finger/Thumb sucking
- Lip Biting
- Nail Biting
- Gum Chewing
- Ice Chewing

Yes No

- Do you drink soda, coffee, tea?  
(caffienated beverages)
- Smoke or Smokeless Tobacco User?

## 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