Dental/Medical Health History Form for Patients Under Age 18

Patient Information

Date _____

Patient's last name _____ First name _____Middle initial_____
Patient prefers to be called _____ Birth date _____ Sex ___ Male ___Female
Social Security #_____School_____Grade_____
Home address _____ City, State, Zip code _____
Home phone ( ) _____-_____ Cell phone ( ) _____-_____ Cell carrier_____
Email Address(es) _____

Who is accompanying your child today?

Name: _____Relation:_____
Do you have legal custody of this child? ____Yes ____No
Parent's marital status: ___Single ___Widowed ___Separated ___Married ___Divorced
List brothers/sisters with age: _____
How did you hear about Sexson Orthodontics? _____

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_____Birthdate_____Email_____
Cell phone #_____ Cell carrier_____ Home phone #_____
Address (if different)_____DL #_____
Employer_____Occupation_____Work phone #_____

Mother's full name_____Birthdate_____Email_____
Cell phone #_____ Cell carrier_____ Home phone #_____
Address (if different)_____DL #_____
Employer_____Occupation_____Work phone #_____

Who is responsible for making appointments?

Name: _____ Relation: _____Best # to contact: _____

Closest Relative / Emergency Contact

Spouse, contact or relatives name(s) _____
Title Mr. Mrs. Ms. Miss. Dr. Other _____ Relationship to patient _____
Address (if different than patient address) _____
Home Phone (If different) ( ) _____-_____ Cell phone ( ) _____-_____ Work phone ( ) _____-_____

Dentist

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 and what would you like orthodontics to accomplish?
_____

What concerns your child about his/her teeth?_____

How does your child feel about orthodontic treatment?_____

Who referred you or suggested that your child might need orthodontic treatment? _____
Why did you select our office? _____
Describe any previous orthodontic treatment or consultations_____
Have any other family members been treated in this office? Please name them_____
Does your child play a musical instrument? _____List type_____

Financial Responsibility

Who is financially responsible for this account? _____Relation_____
Address (if different than page 1) _____ City, State, Zip _____
Home phone ( ) _____-_____ Cell phone ( ) _____-_____ Email address(es) _____
Social Security #_____Driver's License #_____

Dental Insurance

Primary Insurance

Does this policy have orthodontic benefits? ___Yes ___ No ___ Don't Know

Policy holder's full name _____ Birth date _____ Social Security #_____ Relationship to patient _____
Address and phone (if not listed above) _____
Employer _____ Address_____
Insurance company_____ Address_____ Phone #_____
Group #(Plan, Local or Policy #) _____ ID#_____

Secondary Insurance

Does this policy have orthodontic benefits? ___Yes ___ No ___ Don't Know

Policy holder's full name _____ Birth date _____ Social Security #_____ Relationship to patient _____
Address and phone (if not listed above) _____
Employer _____ Address_____
Insurance company_____Address_____Phone #_____
Group # (Plan, Local or Policy #)_____ ID#_____

Physician

Physician _____ Address, City, State_____
Last seen _____ Reason _____ Next appointment _____
Most recent physical exam _____ Other physicians/health care providers being seen now:
Name_____ Address, City, State_____
Reason _____
Name_____ Address, City, State_____
Reason _____

Medical Insurance

Policy holder's full name

_____

Insurance Company

_____

Medical History-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).

Now or in the past, has 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 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)?

☐ ☐ ☐ Does your child eat a well-balanced diet?

☐ ☐ ☐ Frequent headaches or migraines?

☐ ☐ ☐ Frequent ear infections, colds, throat infections?

☐ ☐ ☐ Asthma, sinus problems, hayfever?

☐ ☐ ☐ Tonsil or adenoid condition?

☐ ☐ ☐ Does your frequently breathe through the mouth?

Has your child ever taken intravenous bisphosphonates such as Zometa(zolendromic acid), Aredia(pamidronate) or didronel(etidonate) for bone disorders or cancer? ___Yes ____No ___DK/U

Has your child ever taken oral bisphosophonates such as Fosamax(alendronate), Actonel(ridendronate), Boniva(ibandronate), Skelid(tiludronate) or Didronel(etidronate) for bone disorders? ___Yes ___No ___DK/U

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

☐ ☐ ☐ Local anesthetics (novocaine, lidocaine, xylocaine)

☐ ☐ ☐ Latex (gloves, balloons)

☐ ☐ ☐ Metals (jewelry, clothing snaps)

☐ ☐ ☐ Penicillin or other antibiotics

☐ ☐ ☐ Aspirin or ibuprofen (Motrin, Advil)

☐ ☐ ☐ Acrylics

☐ ☐ ☐ Plant pollens

☐ ☐ ☐ Animals

☐ ☐ ☐ Foods

☐ ☐ ☐ Other substances:_____

Dental History

Now or in the past, has the patient had:

☐ ☐ ☐ Erupting teeth very early or very late?

☐ ☐ ☐ Permanent / extra teeth removed?

☐ ☐ ☐ Supernumerary 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?

☐ ☐ ☐ Difficulty breathing through nose?

☐ ☐ ☐ Food impaction between the teeth?

☐ ☐ ☐ Mouth breathing habit or snoring at night?

☐ ☐ ☐ Primary (baby) teeth removed that were not loose?

☐ ☐ ☐ Frequent oral habits (sucking finger, chewing pen)

☐ ☐ ☐ Teeth causing irritation to lip, cheek or gums?

☐ ☐ ☐ Abnormal swallowing (tongue thrust)?

☐ ☐ ☐ Tooth grinding or clenching?

☐ ☐ ☐ Clicking, locking in jaw joints?

☐ ☐ ☐ Soreness in jaw muscles or face muscles?

☐ ☐ ☐ Ringing in ears, difficulty chewing or opening jaw?

☐ ☐ ☐ Has patient ever been treated for "TMJ" or "TMD"?

☐ ☐ ☐ Any broken or missing fillings?

☐ ☐ ☐ Any trouble with previous dental treatment?

☐ ☐ ☐ Has child ever been diagnosed with gum disease?

☐ ☐ ☐ Has child ever had an injury to their mouth, teeth, or face? _____

☐ ☐ ☐ Has child ever had an orthodontic consultation or treatment previously?

Does/did your child have any of the following habits?

Y N Clenching/Grinding Teeth

Y N Lip Sucking/Biting

Y N Mouth Breather

Y N Nail Biting

Y N Nursing Bottle Habits

Y N Speech Problems

Y N Thumb / Finger Sucking

Y N Tongue Thrust

Patient Health Information

Do you think that any of your child's activities affect his/her face, teeth or jaws? How?_____

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that your child is currently taking.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Does patient take antibiotic pre-medication before any dental procedures? _____
Does patient currently have or ever had a substance abuse problem?_____
Does patient chew or smoke tobacco? _____
Have you noticed any changes in patient's face or jaws? _____
List any other physical problems? _____
How often does patient brush? _____ How often does patient floss? _____

Has puberty begun? ___Yes ___No Has menstruation begun? (Girls) ___Yes ___No

Female Patients: Pregnant? ___Yes ___ No Trying to become pregnant? ___ Yes ___ No Taking birth control? ___Yes ___No

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_____
Signature _____Date_____
Dental Staff Signature _____ Date_____

Changes _____
Signature _____ Date_____
Dental Staff Signature _____ Date_____

I verbally reviewed the medical/dental information above with the patient named herein.

_____ _____ _____ _____
Doctor Signature Date Doctor Signature Date

Doctor's Comments_____