



Medical Dental History Form for Patients Under Age 18

Date _____

Patient's Last Name _____ First Name _____ Middle Initial _____

Prefer to be called: _____ Hobbies, activities _____

Birth date _____ Sex: Male Female Social Security # _____ - _____ - _____

School _____ Grade _____

Home Address _____ City, State, Zip Code _____

Primary phone for appointment reminders (_____) _____ - _____ Alternative phone (_____) _____ - _____

E-mail address(es) for appointment reminders _____

Do you prefer to receive appointment reminders by Email Text

PARENT/GUARDIAN

Custodial parent(s) name(s) _____

Patient lives with (*check all that apply*) mother father stepmother stepfather grandparent(s)

other _____

Who has legal authority to make medical decisions? Mother & Father (married) Mother & Father (divorced-joint custody)
 Father only Mother only Stepmother Stepfather Grandparent(s) Other _____

Father's full name: _____ Title: Mr. Dr. Other _____

Occupation: _____ E-mail address _____

Address (*if different*) _____

Home Phone (*if different*) (_____) _____ - _____ Cell phone (_____) _____ - _____ Work phone (_____) _____ - _____

Mother's full name: _____ Title: Mrs. Ms. Dr. Other _____

Occupation: _____ E-mail address _____

Address (*if different*) _____

Home Phone (*if different*) (_____) _____ - _____ Cell phone (_____) _____ - _____ Work phone (_____) _____ - _____

DENTIST

Patient's Dentist _____

Address, City, State: _____

Last seen _____ Reason _____ Next appointment _____

Other dentist/dental specialists now being seen: Name _____

Address, City, State _____

Reason: _____

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? _____

Why did you select our office? _____

Describe any previous orthodontic treatment or consultations: _____

Does your child play a musical instrument? _____

Brother/sister name _____ age ___ had orthodontic treatment? Yes No If yes, where? _____

Brother/sister name _____ age ___ had orthodontic treatment? Yes No If yes, where? _____

Brother/sister name _____ age ___ had orthodontic treatment? Yes No If yes, where? _____

Brother/sister name _____ age ___ had orthodontic treatment? Yes No If yes, where? _____

Have any other family members been treated in this office? Please name them. _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____

Address (if different from page 1) _____ City, State, Zip _____

Home phone (____) _____ - _____ Cell phone (____) _____ - _____

E-mail address(es) _____

Social Security # _____ - _____ - _____ Employer: _____

Who will be responsible for bringing the patient to orthodontic appointments? _____

DENTAL INSURANCE

Primary policy holder's full name _____ Birthdate _____

Social Security # _____ - _____ - _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance Company _____ Group # _____ ID# _____

Does this policy have orthodontic benefits? Yes No 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, mark yes, no, or don't know/understand (dk/u).

MEDICAL HISTORY

Now or in the past, has your child had:

- yes no dk/u Birth defects or hereditary problems?
- yes no dk/u Bone fractures or major injuries?
- yes no dk/u Any injuries to face, head, neck?
- yes no dk/u Arthritis or joint problems?
- yes no dk/u Cancer, tumor, radiation treatment or chemotherapy?
- yes no dk/u Endocrine or thyroid problems?
- yes no dk/u Diabetes or low sugar?
- yes no dk/u Kidney problems?
- yes no dk/u Immune system problems?
- yes no dk/u History of osteoporosis?
- yes no dk/u Gonorrhea, syphilis, herpes, sexually transmitted diseases?
- yes no dk/u AIDS or HIV positive?
- yes no dk/u Hepatitis, jaundice or other liver problem?
- yes no dk/u Polio, mononucleosis, tuberculosis, pneumonia?
- yes no dk/u Seizures, fainting spells, neurologic problem?
- yes no dk/u Mental health disturbance or depression?
- yes no dk/u History of eating disorder (anorexia, bulimia)?
- yes no dk/u Frequent headaches or migraines?
- yes no dk/u High or low blood pressure?
- yes no dk/u Excessive bleeding or bruising, anemia?
- yes no dk/u Chest pain, shortness of breath, tire easily, swollen ankles?
- yes no dk/u Heart defects, heart murmur, rheumatic heart disease?
- yes no dk/u Angina, arteriosclerosis, stroke or heart attack?
- yes no dk/u Skin disorder (other than common acne)?
- yes no dk/u Does your child eat a well-balanced diet?
- yes no dk/u Vision, hearing, or speech problems?
- yes no dk/u Frequent ear infections, colds, throat infections?
- yes no dk/u Asthma, sinus problems, hayfever?
- yes no dk/u Tonsil or adenoid condition?
- yes no dk/u Does your child frequently breathe through his/her mouth?
- yes no dk/u Has your child ever taken intravenous biophosphonates such as Zometa (zoledronic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?
- yes no dk/u Has your child ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel (risedronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for one disorders?

Do you think your child may need extra attention for orthodontic visits (for example: dental anxiety, ADHD, Autism, Asperger's, Down Syndrome, sensory disorders, etc)

- yes no dk/u If yes, please elaborate: _____

Have you had allergies or reactions to any of the following:

- yes no dk/u Local anesthetics (novocaine, lidocaine, xylocaine)
- yes no dk/u Latex (gloves, balloons)
- yes no dk/u Aspirin
- yes no dk/u Ibuprofen (Motrin, Advil)
- yes no dk/u Penicillin
- yes no dk/u Other Antibiotics
- yes no dk/u Metals (jewelry, clothing snaps)
- yes no dk/u Acrylics
- yes no dk/u Plant pollens
- yes no dk/u Animals
- yes no dk/u Foods
- yes no dk/u Other Substances _____

DENTAL HISTORY

Now or in the past, has the patient had:

- yes no dk/u Erupting teeth very early or very late?
- yes no dk/u Primary (baby) teeth removed that were not loose?
- yes no dk/u Permanent or extra (supernumerary) teeth removed?
- yes no dk/u Supernumerary (extra) or congenitally missing teeth?
- yes no dk/u Chipped or injured primary or permanent teeth?
- yes no dk/u Any sensitive or sore teeth?
- yes no dk/u Any lost or broken fillings?
- yes no dk/u Jaw fractures, cysts, infections?
- yes no dk/u Any teeth treated with root canals or pulpotomies?
- yes no dk/u Frequent canker sores or cold sores?
- yes no dk/u History of speech problems or speech therapy?
- yes no dk/u Difficulty breathing through nose?
- yes no dk/u Mouth breathing habit or snoring at night?
- yes no dk/u History of speech problems?
- yes no dk/u Frequent oral habits (sucking finger, chewing pen, etc.)?
- yes no dk/u Teeth causing irritation to lip, cheek or gums?
- yes no dk/u Tooth grinding or clenching?
- yes no dk/u Clicking, locking in jaw joints?
- yes no dk/u Soreness in jaw muscles or face muscles?
- yes no dk/u Has your child been treated for "TMJ" or "TMD" problems?
- yes no dk/u Any broken or missing fillings?
- yes no dk/u Any serious trouble associated with previous dental treatment?
- yes no dk/u Have you ever been diagnosed with gum disease or pyorrhea?

PATIENT HEALTH INFORMATION

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

If patient is a girl, has menstruation begun: Yes When: _____(Month/Year) No

If patient is a boy, has voice changed or have facial hair: Yes When: _____(Month/Year) No

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 _____

Do you take antibiotic pre-medication before any dental procedures? Yes No

Does the patient currently have (or ever had) a substance abuse problem or use tobacco? _____

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

Any other emotional or physical issues? _____

FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following health problems? If so, please explain.

Severe allergies _____

Unusual dental problems _____

Jaw size imbalance _____

Other severe family medical conditions? _____

How often does your child brush? _____ Floss? _____

RELEASE AND WAIVER

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 _____

Assignment of Benefits: I hereby assign all dental and medical benefits to which I am entitled to Willow Bend Orthodontics. I hereby authorize and direct my insurance carrier(s) to issue payment directly to Willow Bend Orthodontics. I understand that I am responsible for any amount not covered by insurance. I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company necessary to process my claim. A photocopy of this assignment is to be considered as valid as the original.

Parent/Guardian Signature _____ Date _____

I authorize Willow Bend Orthodontics, PLLC or its service provider to contact me via calling, emailing, or texting to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing.

Signature _____ Date _____

I authorize the release of any information regarding any information regarding the dental history and/or treatment to Willow Bend Orthodontics for the purpose of verifying, evaluating, or treating the above mentioned patient.

Signature _____ Date _____

****I hereby certify that I have the authority to sign on behalf of the Patient mentioned above****

(office use only)

MEDICAL HISTORY UPDATES

Orthodontist Initial Review _____ Date _____

Changes _____

Parent/Guardian Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Parent/Guardian Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Parent/Guardian Signature _____ Date _____

Dental Staff Signature _____ Date _____