

ORTHODONTIC

Medical and Dental History for Patients Under 18 Years of Age

Patient's Last Name: _____ First Name: _____ Middle Initial: _____
Preferred Name: _____ Date of Birth: ____/____/____ Age: _____ Gender: M / F
Address: _____ City: _____ State: ____ Zip: _____
Phone #: (Mom Cell) _____ (Dad cell) _____
Social Security #: _____ Email Address: _____
School: _____ (grade) _____
Sports/hobbies/interests: _____
Brothers/sisters: _____ Any siblings treated here? _____

Parent or guardian's name: _____ Other Phone (Specify): _____
Email address: _____

Who is financially responsible for this patient's account? Last name: _____ First: _____ Title: _____
Address (if different): _____
City: _____ State: _____ Zip: _____ Phone #: _____
Employer: _____ Job Title: _____

Insurance Information: Primary policy holder's: Last Name: _____ First: _____ Middle initial: _____
Address (if different from patient): _____
City: _____ State: _____ Zip: _____ Phone #: _____
SSN#: _____ - _____ - _____ Date of Birth: ____/____/____ Employed By: _____
Dental Insurance Company: _____ Group #: _____
Secondary policy holder's name: Last Name: _____ First: _____ Middle initial: _____
Address (if different from patient): _____
City: _____ State: _____ Zip: _____ Phone #: _____
SSN#: _____ - _____ - _____ Date of Birth: ____/____/____ Employed By: _____
Dental Insurance Company: _____ Group #: _____

How did you hear about our office? _____
General dentist's name: _____ City: _____ State: _____
Date of patient's last cleaning: ____/____/____
Physician's name: _____ City: _____ State: _____

For the following questions please mark yes (Y) or no (N). These answers are for office records only and are confidential. A thorough medical history is necessary for a proper orthodontic evaluation.

- MEDICAL HISTORY** Now or in the past has the patient had:
- | | | |
|---|---|---|
| Y | N | Learning disabilities or need extra help with instructions? |
| Y | N | ADD or ADHD? |
| Y | N | Birth defects or hereditary problems? |
| Y | N | Was the patient adopted? |
| Y | N | Rheumatoid or arthritic conditions? |
| Y | N | Endocrine or thyroid problems? |
| Y | N | Diabetes? |
| Y | N | Cancer, tumor, radiation treatment, or chemotherapy? |
| Y | N | Acid reflux? |
| Y | N | Tuberculosis, polio, mononucleosis, or pneumonia? |
| Y | N | Problems of the immune system? |
| Y | N | HIV or AIDS? |
| Y | N | Hepatitis, jaundice, or liver problems? |
| Y | N | Seizures, epilepsy, fainting spells, or neurological problems? |
| Y | N | Mental health disturbance or depression? |
| Y | N | Vision, hearing, taste, or speech difficulties? |
| Y | N | History of eating disorder, anorexia, or bulimia? |
| Y | N | Excessive bleeding or bruising tendency, anemia, or bleeding disorder? |
| Y | N | High or low blood pressure? |
| Y | N | Cardiovascular problems such as shortness of breath, angina, heart attack? |
| Y | N | Heart murmur, rheumatic fever, inborn heart defects, artificial heart valves? |
| Y | N | Allergies or asthma? |
| Y | N | Ear, nose, throat, tonsil, or adenoid conditions? |

Allergies or reactions to any of the following:

- Y N Aspirin or Ibuprofen?
- Y N Penicillin or other antibiotics?
- Y N Codeine or other narcotics?
- Y N Metals?
- Y N Latex?
- Y N Other Substances: _____

Please list any medications, nutrient supplements, herbal medications, or non-prescription medicine the patient is currently taking:

- Y N Does the patient currently have or ever had a substance abuse problem?
- Y N Please list any operations or hospitalizations: _____
- Y N Being treated by another healthcare professional? For _____

For Girls Only:

- Y N Has menstruation begun? When? _____
- Y N Is the patient pregnant?

Dental History

Now or in the past, has the patient had:

- Y N Extra or supernumerary teeth?
- Y N Congenitally missing teeth or any permanent teeth removed?
- Y N Early loss of baby teeth due to decay or trauma?
- Y N Trauma or injury to baby or permanent teeth?
- Y N Jaw fractures, cysts, or mouth infections?
- Y N Periodontal or gum problems?
- Y N Thumb or finger sucking habit? Until what age? _____
- Y N Tongue thrusting?
- Y N History of speech problems?
- Y N Mouth breathing habit?
- Y N Tooth grinding, jaw clenching, clicking, or locking, or other problems of the TMJ?
- Y N Any pain in jaw or face, ringing in the ears, or severe headaches?
- Y N Frequent canker sores or cold sores?
- Y N Any relative with similar tooth or jaw relationships?
- Y N Any relative with jaw size imbalance?
- Y N Ever had a prior orthodontic examination or treatment?

I have read and understand the above questions. I will not hold Bivens Orthodontics responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform the practice.

Signed: _____ Date: _____
(Parent/guardian)

Signed: _____ Date: _____
(Dental Staff member)

For Office Use Only	
Entered:	
Alert:	