American Association of Orthodontists
My Life. My Smile. My Orthodontist.®

CONFIDENTIAL

Medical Dental History Form
For Patients Under Age 18

PATIENT

Date _____

Patient's Last name _____ First name _____ Middle initial _____

Prefers To Be Called _____ Hobbies, activities _____

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

School _____ Grade _____ E-mail address(es) _____

Home address _____ City, State, Zip code _____

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

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 _____ Title ☐ Mr. ☐ Dr. ☐ Other_____

Occupation _____ Email address_____

Address (*if different*) _____

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

Mother's full name _____ Title ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other_____

Occupation _____ Email 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 dentists/dental specialists now being seen: Name _____ 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?_____

Who suggested that your child might need 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 _____ Birth date _____

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

Secondary policy holder's full name _____ Birth date _____

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

MEDICAL INSURANCE

Policy holder's full name _____

Insurance company _____

PHYSICIAN

Patient's Physician _____ City, State _____

Last seen _____ Reason _____ Next appointment_____

Most recent physical exam_____

Other physicians/health care providers being seen now:

Name _____ City, State _____

Reason_____

Name _____ City, State _____

Reason_____

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).*

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 problems?
- ☐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 tendency, 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 bisphosphonates such as Zometa (zolendromic 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 (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders?

Has your child 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 Has your child 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? _____

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? _____

Does your child chew or smoke tobacco? _____

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

Any other physical problems? _____

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? _____

How often does your child brush? _____

Floss? _____

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

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_____