



**WELCOME TO OUR OFFICE**

**MEDICAL DENTAL HISTORY FORM  
UNDER 18**

Date: \_\_\_\_\_ School: \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
LAST FIRST MIDDLE

Mailing Address: \_\_\_\_\_  
STREET CITY STATE ZIP

Physical Address: \_\_\_\_\_  
STREET CITY STATE ZIP

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

If patient is minor, give parent or guardian's name: \_\_\_\_\_

Patient Email: \_\_\_\_\_ Responsible Party Email: \_\_\_\_\_

Method of appointment reminder:  Email  Text: ( \_\_\_\_\_ ) - \_\_\_\_\_ /carrier: \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Name: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
LAST FIRST MIDDLE

Residence Address: \_\_\_\_\_  
STREET CITY STATE ZIP

Mailing Address: \_\_\_\_\_  
STREET/P.O. BOX CITY STATE ZIP

How long at this address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Previous Address (if less than 3 years): \_\_\_\_\_  
STREET CITY STATE ZIP

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Employer: \_\_\_\_\_ No. Years Employed: \_\_\_\_\_

Occupation: \_\_\_\_\_ Occupation No. \_\_\_\_\_  
LAST FIRST MIDDLE

Spouse's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Occupation No. \_\_\_\_\_ Years Employed: \_\_\_\_\_

Spouse's Social Security #: \_\_\_\_\_ Spouse's Birth Date: \_\_\_\_\_

**INSURANCE INFORMATION**

Insured's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Insured's Soc. Sec. #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_ Local No.: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Do you have dual coverage?:  Yes  No If Yes, please continue:

Insured's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Insured's Soc. Sec. #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_ Local No.: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

**EMERGENCY INFORMATION**

Name of nearest relative not living with you: \_\_\_\_\_

Complete Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For the following questions mark yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

**Now or in the past, have you had:**

- yes  no  dk/u Birth defects or hereditary problems?
- yes  no  dk/u Bone fractures, any major accidents?
- yes  no  dk/u Rheumatoid or arthritic conditions?
- yes  no  dk/u Endocrine or thyroid problems?
- yes  no  dk/u Kidney problems?
- yes  no  dk/u Diabetes? If yes, Type I or Type II?
- yes  no  dk/u Cancer, tumor, radiation treatment or chemotherapy?
- yes  no  dk/u Stomach ulcer or hyperacidity?
- yes  no  dk/u Polio, mononucleosis, tuberculosis or pneumonia?
- yes  no  dk/u Problems of the immune system?
- yes  no  dk/u AIDS or HIV positive?
- yes  no  dk/u Hepatitis, jaundice or liver problem?
- yes  no  dk/u Fainting spells, seizures, epilepsy or neurological problem?
- yes  no  dk/u Mental health disturbance or behavioral problem?
- yes  no  dk/u Vision, hearing, tasting or speech difficulties?
- yes  no  dk/u Loss of weight recently, poor appetite?
- yes  no  dk/u History of eating disorder (anorexia, bulimia)?
- yes  no  dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?
- yes  no  dk/u High or low blood pressure?
- yes  no  dk/u Tires easily?
- yes  no  dk/u Chest pain, shortness of breath or swelling ankles?
- yes  no  dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
- yes  no  dk/u Skin disorder?
- yes  no  dk/u Does the patient eat a well-balanced diet?
- yes  no  dk/u Frequent headaches, colds or sore throats?
- yes  no  dk/u Eye, ear, nose or throat condition?
- yes  no  dk/u Tonsil or adenoid conditions?
- yes  no  dk/u Hayfever, asthma, sinus trouble?

**Allergies or reactions to any of the following:**

- yes  no  dk/u Latex (gloves, balloons)
- yes  no  dk/u Metals (jewelry, clothing snaps)
- yes  no  dk/u Local anesthetics, such as Lidocaine
- yes  no  dk/u Acrylic
- yes  no  dk/u Medications (please specify) \_\_\_\_\_
- yes  no  dk/u Foods (please specify) \_\_\_\_\_
- yes  no  dk/u Other substances (specify) \_\_\_\_\_
- yes  no  dk/u Are you taking medication, nutrient supplements, herbal medications or non-prescription medicine? If yes, please name them:

Medication \_\_\_\_\_ Taken for \_\_\_\_\_  
Medication \_\_\_\_\_ Taken for \_\_\_\_\_

- yes  no  dk/u Does the patient currently have or ever had a substance abuse problem?
- yes  no  dk/u Does the patient smoke or chew tobacco?
- yes  no  dk/u Operations? Describe: \_\_\_\_\_
- yes  no  dk/u Hospitalized? For: \_\_\_\_\_
- yes  no  dk/u Being treated by another health care professional?
- If yes, for: \_\_\_\_\_
- yes  no  dk/u Other physical problems or symptoms?
- Describe: \_\_\_\_\_

Are there any other medical conditions (including family medical conditions) that we should be aware of? \_\_\_\_\_

**Who may we thank for referring you to our office:**

\_\_\_\_\_

**General Dentist's Name:** \_\_\_\_\_

**Now or in the past, have you had:**

- yes  no  dk/u Started teething very early or 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 otherwise injured primary (baby) or permanent teeth?
- yes  no  dk/u Teeth sensitive to hot or cold; teeth throb or ache?
- yes  no  dk/u Jaw fractures, cysts or mouth infections?
- yes  no  dk/u "Dead teeth" or root canals treated?
- yes  no  dk/u Bleeding gums, bad taste or mouth odor?
- yes  no  dk/u Periodontal "gum problems"?
- yes  no  dk/u Food impaction between teeth?
- yes  no  dk/u "Gum Boils", frequent canker sores or cold sores?
- yes  no  dk/u Thumb, finger, or sucking habit? Until what age? \_\_\_\_\_
- yes  no  dk/u Abnormal swallowing habit (tongue thrusting)?
- yes  no  dk/u History of speech problems?
- yes  no  dk/u Mouth breathing habit, snoring or difficulty in breathing?
- yes  no  dk/u Tooth grinding, jaw clenching clicking or locking?
- yes  no  dk/u Any pain in jaw or ringing in the ears?
- yes  no  dk/u Any pain or soreness in the muscles of the face or around the ears?
- yes  no  dk/u Difficulty encountered in chewing or jaw opening?
- yes  no  dk/u Aware of loose, broken or missing restorations (fillings)?
- yes  no  dk/u Any teeth irritating cheek, lip, tongue or palate?
- yes  no  dk/u Concerned about spaced, crooked or protruding teeth?
- yes  no  dk/u Aware or concerned about under or over developed jaw?
- yes  no  dk/u Any relative with similar tooth or jaw relationships?
- yes  no  dk/u Any wisdom tooth problems?
- yes  no  dk/u Had periodontal (gum) treatment?
- yes  no  dk/u Had any serious trouble associated with any previous dental treatment?
- yes  no  dk/u Been under another dentist's care?
- yes  no  dk/u Been under another dental specialist's care?
- yes  no  dk/u Ever had a prior orthodontic examination or treatment?
- yes  no  dk/u Would patient object to wearing orthodontic appliances (braces) should they be indicated?

**GIRLS ONLY**

- yes  no  dk/u Has the patient started her monthly periods? If so, approximately when? \_\_\_\_\_
- yes  no  dk/u Are you pregnant?

**PATIENT PROFILE**

- yes  no  dk/u Does patient follow directions well?
- yes  no  dk/u Does patient brush his/her teeth conscientiously?
- yes  no  dk/u Does patient have learning disabilities or need extra help with instructions?
- yes  no  dk/u Is patient self-conscious about teeth?

