Under 18 Medical/Dental History

Dental History

Now or in the past, has your child had:

Y/N Erupting teeth very early or late?
Y/N Baby teeth removed that were not loose?
Y/N Chipped or injured primary (baby) or permanent teeth?
Y/N Any sensitive or sore teeth?
Y/N Frequent canker sores or cold sores?
Y/N History of speech problems or speech therapy?
Y/N Difficulty breathing through nose?
Y/N Mouth breathing habit or snoring at night?
Y/N* Frequent oral habits (sucking finger, chewing pen, etc?)
*No-Age stopped:_____
Y/N* Frequent habit of tongue thrust?
*No-Age stopped: _____
Y/N Teeth causing irritation to lip, cheek or gums?
Y/N Tooth grinding or clenching?
Y/N Clicking, locking in jaw joints?
Y/N Soreness is jaw/muscles?
Y/N Tension headaches?
Y/N Chronic ringing in your ears?
Y/N Any serious trouble associated with previous dental treatment?
Height of parents: Mom:_____ Dad:_____

Medical History

Circle any of the medical conditions now or in the past that your child had or currently has:

Abnormal bleeding/ Hemophilia	Diabetes	Hepatitis/Liver Problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV/Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney Problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there are medical conditions not listed you feel we should be aware of? _____

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

Y/N Latex (gloves, balloons)	Y/N Other antibiotics	Y/N Animals
Y/N Aspirin	Y/N Metals	Y/N Foods
Y/N Ibuprofen (Motrin, Advil)	Y/N Acrylics	
Y/N Penicillin	Y/N Plant Pollens	

Female Patients:
Y/N Are you pregnant?
Y/N Has menstruation started? If yes when_____

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_____

New Patient Information
Patients Under Age 18

PATIENT

Date _____

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

Prefers to be called _____ Hobbies, activities _____

Birth date _____ What sex was the patient assigned on their birth certificate? _Male _Female

What is the patient's current gender identification? _Male _Female _Other

What are the patient's preferred pronouns? _____ School _____ Grade _____

Home address _____ City, State, Zip code _____

Home phone _____ Cell phone _____

PARENT/GUARDIAN

Parent 1/Guardian full name _____

Occupation _____ E-mail address _____

Address (if different) _____

Cell phone (if different) _____ Home phone _____ Work phone _____

Parent 2/Guardian full name _____

Occupation _____ E-mail address _____

Address (if different) _____

Cell phone (if different) _____ Home phone _____ Work phone _____

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# _____

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# _____

PHYSICIAN

Patient's Physician _____ City, State _____

Last seen _____ Reason _____

PATIENT HEALTH INFORMATION

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