

Dental/Medical Health History Form for Patients Under Age 18



**Patient Information**

Date \_\_\_\_\_

Patient's last name \_\_\_\_\_ First name \_\_\_\_\_ Middle initial \_\_\_\_\_

Patient prefers to be called \_\_\_\_\_ Birth date \_\_\_\_\_ Sex  Male  Female

Social Security # \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Home address \_\_\_\_\_ City, State, Zip code \_\_\_\_\_

Home phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell carrier \_\_\_\_\_

Email Address(es) \_\_\_\_\_



**Who is accompanying your child today?**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Do you have legal custody of this child?  Yes  No

Parent's marital status:  Single  Widowed  Separated  Married  Divorced

List brothers/sisters with age: \_\_\_\_\_

How did you hear about Sexson Orthodontics? \_\_\_\_\_



**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 \_\_\_\_\_ Birthdate \_\_\_\_\_ Email \_\_\_\_\_

Cell phone # \_\_\_\_\_ Cell carrier \_\_\_\_\_ Home phone # \_\_\_\_\_

Address (if different) \_\_\_\_\_ DL # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work phone # \_\_\_\_\_

Mother's full name \_\_\_\_\_ Birthdate \_\_\_\_\_ Email \_\_\_\_\_

Cell phone # \_\_\_\_\_ Cell carrier \_\_\_\_\_ Home phone # \_\_\_\_\_

Address (if different) \_\_\_\_\_ DL # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work phone # \_\_\_\_\_



**Who is responsible for making appointments?**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Best # to contact: \_\_\_\_\_

**Closest Relative / Emergency Contact**

Spouse, contact or relatives name(s) \_\_\_\_\_

Title Mr. Mrs. Ms. Miss. Dr. Other \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address (if different than patient address) \_\_\_\_\_

Home Phone (If different) ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Work phone ( ) \_\_\_\_\_ - \_\_\_\_\_

## Dentist

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 and what would you like orthodontics to accomplish?  
\_\_\_\_\_

What concerns your child about his/her teeth? \_\_\_\_\_

How does your child feel about orthodontic treatment? \_\_\_\_\_

Who referred you or suggested that your child might need orthodontic treatment? \_\_\_\_\_

Why did you select our office? \_\_\_\_\_

Describe any previous orthodontic treatment or consultations \_\_\_\_\_

Have any other family members been treated in this office? Please name them \_\_\_\_\_

Does your child play a musical instrument? \_\_\_\_\_ List type \_\_\_\_\_

## Financial Responsibility

Who is financially responsible for this account? \_\_\_\_\_ Relation \_\_\_\_\_

Address (if different than page 1) \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Email address(es) \_\_\_\_\_

Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_



## Dental Insurance

### Primary Insurance

Does this policy have orthodontic benefits? \_\_\_ Yes \_\_\_ No \_\_\_ Don't Know

Policy holder's full name \_\_\_\_\_ Birth date \_\_\_\_\_ Social Security # \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address and phone (if not listed above) \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Insurance company \_\_\_\_\_ Address \_\_\_\_\_ Phone # \_\_\_\_\_

Group # (Plan, Local or Policy #) \_\_\_\_\_ ID# \_\_\_\_\_

### Secondary Insurance

Does this policy have orthodontic benefits? \_\_\_ Yes \_\_\_ No \_\_\_ Don't Know

Policy holder's full name \_\_\_\_\_ Birth date \_\_\_\_\_ Social Security # \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address and phone (if not listed above) \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Insurance company \_\_\_\_\_ Address \_\_\_\_\_ Phone # \_\_\_\_\_

Group # (Plan, Local or Policy #) \_\_\_\_\_ ID# \_\_\_\_\_

## Physician

Physician \_\_\_\_\_ Address, City, State \_\_\_\_\_

Last seen \_\_\_\_\_ Reason \_\_\_\_\_ Next appointment \_\_\_\_\_

Most recent physical exam \_\_\_\_\_ Other physicians/health care providers being seen now:

Name \_\_\_\_\_ Address, City, State \_\_\_\_\_

Reason \_\_\_\_\_

Name \_\_\_\_\_ Address, City, State \_\_\_\_\_

Reason \_\_\_\_\_

## Medical Insurance

Policy holder's full name

Insurance Company

**Medical History-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).

### Now or in the past, has your child had:

Yes No DK/U

- |  |  |
|--|--|
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Birth defects or hereditary problems?                       | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Seizures, fainting spells, neurologic problems?               |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bone fractures or major injuries?                           | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Mental health disturbance or depression?                      |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Any injuries to face, head, neck?                           | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vision, hearing, or speech problems?                          |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arthritis or joint problems?                                | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> History of eating disorder (anorexia, bulimia)?               |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Endocrine or thyroid problems?                              | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High or low blood pressure?                                   |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diabetes or low sugar?                                      | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive bleeding or bruising, anemia?                       |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney problems?  | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest pain, shortness of breath, tire easily, swollen ankles? |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cancer, tumor, radiation or chemotherapy?                   | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Heart defects, heart murmur rheumatic heart disease?          |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Stomach ulcer, hyperacidity, acid reflux?                   | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Angina, arteriosclerosis, stroke or heart attack?             |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Immune system problems?                                     | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Skin disorder (other than common acne)?                       |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> History of osteoporosis?                                    | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Does your child eat a well-balanced diet?                     |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gonorrhea, syphilis, herpes, sexually transmitted diseases? | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent headaches or migraines?                              |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> AIDS or HIV positive?                                       | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent ear infections, colds, throat infections?            |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hepatitis, jaundice, or other liver problems?               | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma, sinus problems, hayfever?                             |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Polio, mononucleosis, tuberculosis, pneumonia?              | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tonsil or adenoid condition?                                  |
|  | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Does your frequently breathe through the mouth?               |

Has your child ever taken intravenous bisphosphonates such as Zometa(zolendromic acid), Aredia(pamidronate) or didronel(etidonate) 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? \_\_\_Yes \_\_\_No \_\_\_DK/U

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

- Local anesthetics (novocaine, lidocaine, xylocaine)
- Latex (gloves, balloons)
- Metals (jewelry, clothing snaps)
- Penicillin or other antibiotics
- Aspirin or ibuprofen (Motrin, Advil)
- Acrylics
- Plant pollens
- Animals
- Foods
- Other substances: \_\_\_\_\_



**Dental History**

**Now or in the past, has the patient had:**

- Erupting teeth very early or very late?
- Permanent / extra teeth removed?
- Supernumerary or congenitally missing teeth?
- Chipped or injured primary or permanent teeth?
- Any sensitive or sore teeth?
- Bleeding gums, bad taste or mouth odor?
- Jaw fractures, cysts, infections?
- Any teeth treated with root canals or pulpotomies?
- "Gum boils," frequent canker sores or cold sores?
- History of speech problems or speech therapy?
- Difficulty breathing through nose?
- Food impaction between the teeth?
- Mouth breathing habit or snoring at night?
- Primary (baby) teeth removed that were not loose?
- Frequent oral habits (sucking finger, chewing pen)
- Teeth causing irritation to lip, cheek or gums?
- Abnormal swallowing (tongue thrust)?
- Tooth grinding or clenching?
- Clicking, locking in jaw joints?
- Soreness in jaw muscles or face muscles?
- Ringing in ears, difficulty chewing or opening jaw?
- Has patient ever been treated for "TMJ" or "TMD"?
- Any broken or missing fillings?
- Any trouble with previous dental treatment?
- Has child ever been diagnosed with gum disease?
- Has child ever had an injury to their mouth, teeth, or face? \_\_\_\_\_
- Has child ever had an orthodontic consultation or treatment previously?

**Does/did your child have any of the following habits?**

- |   |   |                          |   |   |                        |
|---|---|--------------------------|---|---|------------------------|
| Y | N | Clenching/Grinding Teeth | Y | N | Nursing Bottle Habits  |
| Y | N | Lip Sucking/Biting       | Y | N | Speech Problems        |
| Y | N | Mouth Breather           | Y | N | Thumb / Finger Sucking |
| Y | N | Nail Biting              | Y | N | Tongue Thrust          |

**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 is currently taking.

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

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

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

Does patient take antibiotic pre-medication before any dental procedures? \_\_\_\_\_

Does patient currently have or ever had a substance abuse problem? \_\_\_\_\_

Does patient chew or smoke tobacco? \_\_\_\_\_

Have you noticed any changes in patient's face or jaws? \_\_\_\_\_

List any other physical problems? \_\_\_\_\_

How often does patient brush? \_\_\_\_\_ How often does patient floss? \_\_\_\_\_

Has puberty begun? \_\_\_Yes \_\_\_No Has menstruation begun? (Girls) \_\_\_Yes \_\_\_No

Female Patients: Pregnant? \_\_\_Yes \_\_\_No Trying to become pregnant? \_\_\_Yes \_\_\_No Taking birth control? \_\_\_Yes \_\_\_No

**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? \_\_\_\_\_

**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 or Changes**

Changes \_\_\_\_\_

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

Dental Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

Changes \_\_\_\_\_

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

Dental Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

I verbally reviewed the medical/dental information above with the patient named herein.

\_\_\_\_\_  
Doctor Signature Date Doctor Signature Date

Doctor's Comments \_\_\_\_\_