



Medical / Dental History Form – Under 18

PATIENT

Today's Date: ___/___/___

Patient's Last Name: _____ First Name: _____ Middle Initial: _____

Prefers to be called: _____ Date of Birth: ___/___/___ Gender: Male Female

Hobbies and Activities: _____

School: _____ Grade Level: _____

Siblings (Name and Age): _____

PARENT/GUARDIAN

Parent(s)/Guardian(s) Full Name(s): _____

Relationship to Patient: _____

DENTIST

Has your child had a dental check-up within the last 6 months? Yes; No

Patient's Dentist: _____ Date of Last Visit: ___/___/___

Other dentists/dental specialists being seen? _____

PATIENT / FAMILY HEALTH INFORMATION

Please 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: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Does your child require antibiotic pre-medication before any dental procedures? _____

Does your child chew, smoke, or vape any tobacco product? _____

Has the patients' mother and/or father ever had orthodontic treatment? _____

Did the mother and/or father require jaw surgery as part of orthodontic treatment: _____

For the following question, please mark yes, no, or don't know/understand (dk/u). Please mark each question individually, do NOT draw a line through all answers. Thank you.

Medical History

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

Yes No DK/U

- Birth defects or hereditary problems?
Bone fractures of major injuries?
Any injuries to face, head, neck?
Arthritis or joint problems?
Seizures, fainting spells, neurological problems?
Mental health disturbances and/or depression?
Frequent headaches or migraines?
Heart defects, heart murmur, rheumatic heart disease?
Does your child frequently breath through his/her mouth?
Has your child ever taken intravenous bisphosphanates for bone disorders or cancer?
Has your child ever taken oral bisphosphanates for bone disorders?
Surgeries: _____

Dental History

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

Yes No DK/U

- Erupting teeth very early or very late?
Primary (baby) teeth removed that were not loose?
Permanent teeth removed?
Congenitally missing teeth?
Presence of extra (supernumerary) teeth?
Chipped or injured primary or permanent teeth?
Any sensitive or sore teeth?
Any lost or broken fillings?
Jaw fractures, cysts, or infections?
Any teeth treated with root canals or pulpotomies?
Frequent canker sores or cold sores?
History or speech problems or speech therapy?
Difficulty breathing through nose?
Mouth breathing habit or snoring at night?
Frequent oral habits (fingers, thumbs, pens, etc.)
Teeth cause irritation to lip, cheek, or gums?
Tooth grinding or clenching?
Clicking, locking of jaw joints?
Soreness in jaw or face muscles?
Has your child been treated for "TMJ" or "TMD" problems?
Any trouble associated with prior dental treatment?
Has your child ever been diagnosed with periodontal (gum) disease?

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

Yes No DK/U

- Latex (gloves, balloons)
Aspirin
Ibuprofen (Motrin, Advil)
Metals (jewelry, clothing snaps)
Acrylics
Other substances: _____

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: ____/____/____

Do Not Write Below This Line

MEDICAL HISTORY UPDATES OR CHANGES

Changes: _____

Parent/Guardian Signature: _____ Date: ____/____/____

Staff Signature: _____ Date: ____/____/____