American Association of Orthodontists®

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 _____ 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? _____

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*) ☐ Parent 1/Guardian ☐ Parent 2/Guardian ☐ Parent 3/Guardian ☐ Parent 4/Guardian

☐ Other, if other, what is the relationship? _____

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 _____

DENTIST

Patient's Dentist _____ Address, City, State _____

Last seen _____ Reason _____ Next appointment _____

Other dentists/dental specialists now being seen: Name _____ City, State _____

Reason _____

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GENERAL INFORMATION

What concerns you about your child's teeth? _____

What concerns your child about his/her/their 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? _____

Sibling name _____ age _____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Sibling name _____ age _____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Sibling name _____ age _____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Sibling 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 than page 1*) _____ City, State, Zip _____

Cell phone _____ Home 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 _____

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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 _____

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, mark yes, no, or don't know/understand (dl/u).

PATIENT HEALTH INFORMATION

Does the patient take antibiotic pre-medication before any dental procedures? ☐ Yes ☐ No

Does the patient currently have (or ever had) a substance abuse problem? _____

Do you think that any of your child's activities affect his/her/their 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 _____

Does your child chew or smoke tobacco? _____

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

Any other physical problems? _____

MEDICAL HISTORY

Now or in the past, has your child had:

Yes	No	DK/U	
☐	☐	☐	Emotional, sensory or developmental issues?
☐	☐	☐	Hereditary or developmental conditions?
☐	☐	☐	Bone fractures or major injuries?
☐	☐	☐	Any injuries to face, head, neck?
☐	☐	☐	Arthritis or joint problems?
☐	☐	☐	Cancer, tumor, radiation treatment or chemotherapy?
☐	☐	☐	Endocrine or thyroid problems?
☐	☐	☐	Diabetes or low sugar?
☐	☐	☐	Kidney problems?
☐	☐	☐	Immune system problems?
☐	☐	☐	History of osteoporosis?
☐	☐	☐	Gonorrhea, syphilis, herpes, sexually transmitted diseases?
☐	☐	☐	AIDS or HIV positive?
☐	☐	☐	Hepatitis, jaundice, or other liver problems?
☐	☐	☐	Polio, mononucleosis, tuberculosis, pneumonia?
☐	☐	☐	Seizures, fainting spells, neurologic problems?
☐	☐	☐	Mental health disturbance or depression?
☐	☐	☐	History of eating disorder (anorexia, bulimia)?
☐	☐	☐	Frequent headaches or migraines

Yes	No	DK/U	
☐	☐	☐	High or low blood pressure?
☐	☐	☐	Excessive bleeding or bruising, anemia?
☐	☐	☐	Chest pain, shortness of breath, tire easily, swollen ankles?
☐	☐	☐	Heart defects, heart murmur, rheumatic heart disease?
☐	☐	☐	Angina, arteriosclerosis, stroke or heart attack?
☐	☐	☐	Skin disorder (other than common acne)?
☐	☐	☐	Does your child eat a well-balanced diet?
☐	☐	☐	Vision, hearing, or speech problems?
☐	☐	☐	Frequent ear infections, colds, throat infections?
☐	☐	☐	Asthma, sinus problems, hayfever?
☐	☐	☐	Tonsil or adenoid condition?
☐	☐	☐	Does your child frequently breathe through his/her mouth?
☐	☐	☐	Has your child ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate)?
☐	☐	☐	Has your child ever taken oral medication for bone disorders or cancer such as bisphosphonates such as Fosamax (alendronate), Actonel(ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate)?

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MEDICAL HISTORY continued

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

Yes	No	DK/U	
☐	☐	☐	Local anesthetics (novocaine, lidocaine, xylocaine)
☐	☐	☐	Latex (gloves, balloons)
☐	☐	☐	Aspirin
☐	☐	☐	Ibuprofen (Motrin, Advil)
☐	☐	☐	Penicillin
☐	☐	☐	Other antibiotics
☐	☐	☐	Metals (jewelry, clothing snaps)
☐	☐	☐	Acrylics
☐	☐	☐	Plant pollens
☐	☐	☐	Animals
☐	☐	☐	Foods
☐	☐	☐	Other substances _____

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 or extra (supernumerary) teeth removed?
☐	☐	☐	Supernumerary (extra) or congenitally missing teeth?
☐	☐	☐	Chipped or injured primary or permanent teeth?
☐	☐	☐	Any sensitive or sore teeth?
☐	☐	☐	Any lost or broken fillings?
☐	☐	☐	Jaw fractures, cysts, infections?
☐	☐	☐	Any teeth treated with root canals or pulpotomies?
☐	☐	☐	Frequent canker sores or cold sores?
☐	☐	☐	History of speech problems or speech therapy?
☐	☐	☐	Difficulty breathing through nose?
☐	☐	☐	Mouth breathing habit or snoring at night?
☐	☐	☐	History of speech problems?
☐	☐	☐	Frequent oral habits (sucking finger, chewing pen, etc)?
			Current ___ Yes ___ No Age stopped ___
☐	☐	☐	Frequent habit of tongue thrust?
			Current ___ Yes ___ No Age stopped ___
☐	☐	☐	Frequent habit of fingernail biting?
			Current ___ Yes ___ No Age stopped ___
☐	☐	☐	Frequent habit of lip sucking?
			Current ___ Yes ___ No Age stopped ___
☐	☐	☐	Teeth causing irritation to lip, cheek or gums?
☐	☐	☐	Tooth grinding or clenching?
☐	☐	☐	Clicking, locking in jaw joints?
☐	☐	☐	Soreness in jaw muscles or face muscles?
☐	☐	☐	Has your child been treated for “TMJ” or “TMD” problems?
☐	☐	☐	Any broken or missing fillings?
☐	☐	☐	Any serious trouble associated with previous dental treatment?
☐	☐	☐	Has your child ever been diagnosed with gum disease or pyorrhea?

How often does your child brush? _____ Floss? _____

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 _____
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 _____

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