CONFIDENTIAL

Medical Dental History
Form For Children and Young Adults

Today's Date _____

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

School _____ Birthdate _____ Grade _____ Age _____

☐ Male ☐ Female Primary Doctor _____ Prefers to be called _____

Your Primary Dentist _____ Who referred you to our office _____

Home Address _____ City _____ State _____ Zip _____

Father's Name _____ Occupation _____ Employer _____

Mother's Name _____ Occupation _____ Employer _____

Father's Work Phone _____ Mother's Work Phone _____ Marital Status: ☐ Single ☐ Married ☐ Divorced

Names and Ages of Siblings _____

Mother's Email Address _____ Father's Email Address _____

Billing Party's Information: Name _____ ***Social Security #*** _____

Billing Party Phone # : (Mobile) _____ ***(Home)*** _____ ***(Work)*** _____

Please check "yes" or "no" for all of the following medical questions

Are you in good health .....Yes ☐ No ☐
Do you have diabetes .....Yes ☐ No ☐
Birth defect/hereditary problem..Yes ☐ No ☐
Arthritis or joint problems.....Yes ☐ No ☐
History of osteoporosis.....Yes ☐ No ☐
Tonsil or adenoid condition.....Yes ☐ No ☐
Missing or Extra teeth.....Yes ☐ No ☐
Chipped or injured teeth.....Yes ☐ No ☐
Family History of Jaw Surgery...Yes ☐ No ☐

History of any jaw injury.....Yes ☐ No ☐
Sleep with mouth open.....Yes ☐ No ☐
Mouth breath during day.....Yes ☐ No ☐
Breathing trouble.....Yes ☐ No ☐
Finger habit (thumb sucking)..Yes ☐ No ☐
Tongue habit.....Yes ☐ No ☐
Teeth grinding or clinching .....Yes ☐ No ☐
Clicking or popping jaw.....Yes ☐ No ☐
Tobacco use.....Yes ☐ No ☐

Heart trouble.....Yes ☐ No ☐
Rheumatic Fever.....Yes ☐ No ☐
Prosthetic Limb.....Yes ☐ No ☐
Heart Murmur.....Yes ☐ No ☐
Allergy to Metal.....Yes ☐ No ☐
Herpes/syphilis/gonorrhea..Yes ☐ No ☐
AIDS or HIV positive.....Yes ☐ No ☐
Hepatitis A,B,or C.....Yes ☐ No ☐
Latex Sensitivity..... Yes ☐ No ☐

Has the Patient Started Puberty yes / no Boys: Has his voice changed yes / no Girls: Has she started Menstration yes / no

Please list all medications currently taking _____

List Any Allergies or Drug Sensitivity _____

_____

Please list any treatments had by a doctor in the last year _____

_____

Are there any problems with Clicking, Popping or Pain in the Jaw Joint? _____

Any previous injuries or surgery to the Face, Mouth, or Teeth? _____

Any Speech Problems? _____

Does He/She Mouth Breathe while sleeping? _____

Does He/She Mouth Breathe while awake? _____

Does He/She have any missing teeth? _____

Does the patient have any problems with their Gums? _____

Has an Orthodontist been consulted previously? _____

Has He/She ever had Orthodontic treatment? _____

Has anyone in your family had treatment in our office? _____

What is your primary reason for getting an orthodontic consult? _____

Responsible party's name, address, and phone number _____

_____

Parent's Signature _____