

Dental and Medical History

What are the main concerns that you would like orthodontics to accomplish?

Has your child ever been evaluated or had orthodontic treatment before? Y N

Have there been any injuries to the face, mouth, teeth or chin? Y N

Does the child require antibiotics before dental treatment? Y N

Have adenoids or tonsils been removed? Y N

Does your child have any missing or extra permanent teeth? Y N

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? Y N

Does the child brush teeth daily? Y N Floss daily? Y N

Child's Physician: _____

Ph #: (_____) _____ Date of last visit: _____

Is the child currently under the care of a physician? Y N

Has puberty begun? Y N

GIRLS: Has menstruation begun? Y N

Indicate the child's current physical health: Good Fair Poor

Please list all drugs that the child is currently taking:

Does your child have allergies to any of the following?

Latex Y N Nickel/Metals Y N Plastic Y N

Please list any other allergies that the child may have:

Has the child experienced the following medical problems?

- | | | | | | |
|---|---|--------------------------------|---|---|----------------------------|
| Y | N | Abnormal Bleeding | Y | N | Hearing Impairment |
| Y | N | ADD/ADHD | Y | N | Heart Murmur |
| Y | N | AIDS/HIV+ | Y | N | Hemophilia |
| Y | N | Any Hospital Stays/Operations | Y | N | Hepatitis |
| Y | N | Artificial Bones/Joints/Valves | Y | N | Kidney Problems |
| Y | N | Asthma | Y | N | Liver Problems |
| Y | N | Cancer | Y | N | Mitral Valve Prolapse |
| Y | N | Congenital Heart Defect | Y | N | Prosthetics |
| Y | N | Convulsions | Y | N | Rheumatic Fever |
| Y | N | Diabetes | Y | N | Scarlet Fever |
| Y | N | Epilepsy | Y | N | Sickle Cell Disease/Traits |
| Y | N | Handicaps/Disabilities | Y | N | Tuberculosis (TB) |

Are the child's immunizations current? Y N

Would you like to discuss anything with the Doctor in private? Y N

Please list any serious medical problems the child has had:

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

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

List any musical instruments played: _____

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental/orthodontic services that my child may need.

SIGNATURE OF PARENT OR GUARDIAN

DATE

OFFICE USE ONLY

Doctor's Comments: _____

I have verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

SIGNATURE OF DOCTOR

DATE

Medical History Update

Has there been any change in your child's health status since their last visit? Y N

If yes, please explain: _____

Has there been any changes in your child's health status since their last visit? Y N

If yes, please explain: _____

PARENT/GUARDIAN SIGNATURE

DATE

DOCTOR SIGNATURE

DATE

PARENT/GUARDIAN SIGNATURE

DATE

DOCTOR SIGNATURE

DATE