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American Association of Orthodontists

MEDICAL DENTAL HISTORY FORM

Date: _____

Patient's Last Name: _____ First _____ Middle _____

Birthday: _____ Age: _____ Sex: _____ Home Phone No. _____

Patient's Address: (P.O. BOX#) _____ (STREET ADDRESS)_____

City: _____ State:_____ Zip Code: _____

Name of Responsible Party: _____ Phone No.# _____

Address of Resp. Party: _____

S.S.# _____ Employer: _____

Address of Employer: _____ Phone No.# _____

Name of Patient's Dentist: _____ Address: _____ Phone No.# _____

Name of Medical Doctor: _____ Address: _____ Phone No.# _____

Number of Brother or Sisters: _____ Their Names: _____

Has any other family member been treated here: _____ Who:_____

Musical Instrument Played: _____ Favorite Sports/Hobbies: _____

Patient's School: _____ Grade: _____

Do you have ORTHODONTIC Insurance: (YES) _____ (NO) _____

INSURANCE

Primary Insurance Co. _____ Group No. _____ Employer _____
Insured Name _____ S.S.# I.D.# _____ Subscriber DOB _____
Address: _____ City _____ State _____ Zip Code _____
Secondary Insurance Co. _____ Group No. _____ Employer _____
Insured Name _____ S.S.# I.D.# _____ Subscriber DOB _____
Address: _____ City _____ State _____ Zip Code _____

In case we can't reach you:

Person to contact: _____ Phone No.: _____

For the following questions circle YES or NO or DON'T KNOW/UNDERSTAND (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

yes no dk/u Does patient follow directions?
yes no dk/u Does patient brush his/her teeth conscientiously?
yes no dk/u Does patient have learning disabilities or need help with instructions?
yes no dk/u Is patient sensitive, self-conscious?

MEDICAL HISTORY

yes no dk/u Birth defects or hereditary problems?
yes no dk/u Bone fractures, any major accidents?
yes no dk/u Rheumatoid or arthritic conditions?
yes no dk/u Endocrine or thyroid problems?
yes no dk/u Kidney problems?
yes no dk/u Diabetes?
yes no dk/u Cancer or been treated for a tumor?
yes no dk/u Stomach ulcer or hyperacidity?
yes no dk/u Polio, mono, tuberculosis, pneumonia?
yes no dk/u Problems of the immune system?
yes no dk/u AIDS or HIV positive?
yes no dk/u Hepatitis, jaundice or liver problems?
yes no dk/u Fainting spells, seizures?
yes no dk/u Mental health or behavorial problems?
yes no dk/u Vision, hearing, tasting or speech difficulties?
yes no dk/u Loss of weight recently, poor appetite?
yes no dk/u Excessive bleeding, black and blue tendency, anemia or bleeding disorder?

yes no dk/u High or Low blood pressure?
yes no dk/u Tires easily?
yes no dk/u Chest pain, shortness of breath, swelling ankles?
yes no dk/u Cardiovascular problems (heart attack, heart trouble, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects or rheumatic heart?
yes no dk/u Skin disorder?
yes no dk/u Do you have a normal or good diet?
yes no dk/u Frequent headaches, colds or sore throat?
yes no dk/u Eye, ear, nose, throat condition?
yes no dk/u Hayfever, asthma, sinus trouble, hives?
yes no dk/u Tonsil or adenoid conditions?
yes no dk/u Allergies or drug reactions?
yes no dk/u Are you taking medication, nutrient supplement or non prescription medicine? Name them:
_____
_____

Over →

yes no dk/u Does the patient currently have or ever had a substance abuse problem?
yes no dk/u Operations? (Surgical Procedures)? _____
yes no dk/u Hospitalized for_____
yes no dk/u Other physical problems or symptoms?_____
yes no dk/u Being treated by another health care professional?
For: _____
Date of most recent physical exam:_____

DENTAL HISTORY

yes no dk/u Started teething very early or late?
yes no dk/u Primary (baby) teeth removed that were loose?
yes no dk/u Permanent or extra (supernumerary) teeth removed?
yes no dk/u Chipped or otherwise injured primary (baby) teeth?
yes no dk/u Teeth sensitive to hot or cold: teeth throb or ache?
yes no dk/u Jaw fractures, cyst, mouth infections?
yes no dk/u Dead teeth, root canals treated?
yes no dk/u Bleeding gums, bad taste, mouth odor?
yes no dk/u Periodontal "Gum problems"?
yes no dk/u Food impaction between teeth?
yes no dk/u Gum boils, frequent canker sores, cold sores?
yes no dk/u Is child taking any forms of fluoride?
yes no dk/u Thumb, or finger sucking habit? Until _____
yes no dk/u Abnormal swallowing habit (tongue thrusting)?
yes no dk/u History of speech problems?
yes no dk/u Mouth breathing habit, snoring, difficulty in breathing?
yes no dk/u Tooth grinding, jaw clenching, clicking, locking?
yes no dk/u Any pain in jaw or ringing in the ears?
yes no dk/u Does the patient experience any pain or soreness in the muscles of the face, or around the ears?
yes no dk/u Difficulty encountered in chewing or jaw opening?
yes no dk/u Aware of loose, broken or missing restorations (fillings)?
yes no dk/u Any teeth irritating cheek, lip, tongue, palate?
yes no dk/u Concerned about spaced, crooked or protruding teeth?
yes no dk/u Aware or concerned about under or over developed jaw?
yes no dk/u Any relative with similar tooth or jaw relationships?
yes no dk/u Any wisdom tooth problems?
yes no dk/u Has patient had any serious trouble associated with any previous dental treatment?
yes no dk/u Onset of puberty (approx. date) _____

yes no dk/u Has patient ever had a prior orthodontic examination or treatment?
yes no dk/u Has patient recently been under another Dentist care?
yes no dk/u Has patient ever had Gum treatment?
yes no dk/u Would patient object to wearing orthodontic appliances (braces) should they be indicated?

Date of most recent dental examination:_____

How often does patient brush? _____

Floss? _____

What is the patient's (or parent's) primary concern?

_____

_____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining good oral hygiene, are there any restrictions, handicaps or problems that might be encountered during treatment?

I have read and understand the above questions. 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. If there are any changes later to this history record or medical/dental status I will so inform this practice.

Signature of Parent or Guardian _____ Date _____

Medical History update or changes: Date: Comment: Signature:

_____

_____

_____

_____