JEFF THOMPSON
ORTHODONTICS

CONFIDENTIAL MEDICAL DENTAL HISTORY
FOR PATIENTS UNDER 18 YEARS OF AGE

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

Birth Date: _____ Age: _____ Sex: Male ❑ Female ❑ Prefers to be Called: _____

S.S.N./S.I.N.: _____ Home Phone No: (_____) _____

Father's Cell Phone No: (_____) _____ Mother's Cell Phone No: (_____) _____

Patient's Address: _____ City: _____

State: _____ Zip/Postal Code: _____ Resposible Party email address: _____

School Name: _____ Grade: _____ Musical Instruments Played: _____

Sports and/or Hobbies: _____

No. of brothers and sisters: _____ Ages: _____

Other family members treated here: _____

Who referred you to our office? _____

Father's name: _____ Home Phone: _____

Address: _____

Mother's name: _____ Home Phone: _____

Address: _____

Father's Employer: _____ Father's Work Phone: _____

Mother's Employer: _____ Mother's Work Phone: _____

PRIMARY INSURANCE INFORMATION

Name of Insured: _____

Date of Birth: _____

Social Security #: _____ - _____ - _____

Employer: _____

Work Phone: _____

Employer Address: _____

City _____ State _____ Zip _____

Insurance Company: _____

Group #: _____

Address: _____

Insurance Co. Phone No.: _____

SECONDARY INSURANCE INFORMATION

Name of Insured: _____

Date of Birth: _____

Social Security #: _____ - _____ - _____

Employer: _____

Work Phone: _____

Employer Address: _____

City _____ State _____ Zip _____

Insurance Company: _____

Group #: _____

Address: _____

Insurance Co. Phone No.: _____

PATIENT PROFILE

- ☐ Yes ☐ No Does patient follow directions well?
- ☐ Yes ☐ No Does patient brush his/her teeth conscientiously?
- ☐ Yes ☐ No Does patient have learning disabilities or need extra help with instructions?
- ☐ Yes ☐ No Is patient sensitive or self-conscious about their smiles?

MEDICAL HISTORY : Now or in the past, has the patient had:

- ☐ Yes ☐ No Birth defects or hereditary problems?
- ☐ Yes ☐ No Bone fractures, any major accidents?
- ☐ Yes ☐ No Rheumatoid or arthritic conditions?
- ☐ Yes ☐ No Endocrine or thyroid problems?
- ☐ Yes ☐ No Kidney problems?
- ☐ Yes ☐ No Diabetes?
- ☐ Yes ☐ No Cancer, tumor, radiation treatment or chemotherapy?
- ☐ Yes ☐ No Stomach ulcer or hyperacidity?
- ☐ Yes ☐ No Polio, mononucleosis, tuberculosis or pneumonia?
- ☐ Yes ☐ No Problems of the immune system?
- ☐ Yes ☐ No AIDS or HIV positive?
- ☐ Yes ☐ No Hepatitis, jaundice or liver problems?
- ☐ Yes ☐ No Fainting spells, seizures, epilepsy or neurological problem?
- ☐ Yes ☐ No Mental health disturbance or behavioral problem?
- ☐ Yes ☐ No Vision, hearing, tasting or speech difficulties?
- ☐ Yes ☐ No Loss of weight recently, poor appetite?
- ☐ Yes ☐ No History of eating disorder (anorexia, bulimia)?
- ☐ Yes ☐ No Bleeding disorder, bruising tendency, excessive bleeding or anemia?
- ☐ Yes ☐ No High or low blood pressure?
- ☐ Yes ☐ No Tires easily?
- ☐ Yes ☐ No Chest pain, shortness of breath or swelling ankles?
- ☐ Yes ☐ No Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
- ☐ Yes ☐ No Skin disorder?
- ☐ Yes ☐ No Does the patient eat a well-balanced diet?
- ☐ Yes ☐ No Frequent headaches, colds or sore throats?
- ☐ Yes ☐ No Eye, ear, nose or throat condition?
- ☐ Yes ☐ No Hayfever, asthma, sinus trouble or hives?
- ☐ Yes ☐ No Tonsil or adenoid conditions?

GIRLS ONLY

- ☐ Yes ☐ No Has the patient started her monthly periods?

  If so, approximately when? _____
- ☐ Yes ☐ No Is the patient pregnant?

Allergies or reactions to any of the following:

- ☐ Yes ☐ No Local anesthetics (Novocaine or Lidocaine)?
- ☐ Yes ☐ No Aspirin?
- ☐ Yes ☐ No Ibuprofen (Motrin, Advil)?
- ☐ Yes ☐ No Penicillin or other antibiotics?
- ☐ Yes ☐ No Sulfa drugs?
- ☐ Yes ☐ No Codeine or other narcotics?
- ☐ Yes ☐ No Metals (jewelry, clothing snaps)?
- ☐ Yes ☐ No Latex (gloves, balloons)?
- ☐ Yes ☐ No Vinyl?
- ☐ Yes ☐ No Acrylic?
- ☐ Yes ☐ No Animals?
- ☐ Yes ☐ No Foods (specify)? _____
- ☐ Yes ☐ No Other substances (specify)? _____

_____

- ☐ Yes ☐ No Is the patient taking medication, nutrient supplements, herbal medications or non-prescription medicine? Please name them.

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

- ☐ Yes ☐ No Does the patient currently have or ever had a substance abuse problem?
- ☐ Yes ☐ No Does the patient chew or smoke tobacco?
- ☐ Yes ☐ No Operations? (specify) _____
- ☐ Yes ☐ No Hospitalized? (for) _____
- ☐ Yes ☐ No Other physical problems or symptoms? (describe) _____
- ☐ Yes ☐ No Being treated by another health care professional? (for) _____

Date of most recent physical exam: _____

- ☐ Yes ☐ No Are there any other medical conditions that we should be aware of?

_____

DENTAL HISTORY: Now or in the past, has the patient had:

- ❑ Yes ❑ No Primary teeth removed that were not loose?
- ❑ Yes ❑ No Permanent or "extra" (supernumerary) teeth removed?
- ❑ Yes ❑ No Chipped or otherwise injured teeth?
- ❑ Yes ❑ No Teeth sensitive to hot or cold; throb or ache?
- ❑ Yes ❑ No Jaw fractures, cysts or mouth infections?
- ❑ Yes ❑ No "Dead teeth" or root canals treated?
- ❑ Yes ❑ No Bleeding gums, bad taste or mouth odor?
- ❑ Yes ❑ No Started teething very early or late?
- ❑ Yes ❑ No Periodontal "gum" problems?
- ❑ Yes ❑ No Food impaction between teeth?
- ❑ Yes ❑ No Thumb, finger, or sucking habit? Until what age? _____
- ❑ Yes ❑ No Abnormal swallowing habit (tongue thrust)?
- ❑ Yes ❑ No History of speech problems?
- ❑ Yes ❑ No Mouth breathing habit, snoring or difficulty in breathing?

- ❑ Yes ❑ No Tooth grinding, jaw clenching, clicking or locking?
- ❑ Yes ❑ No Any pain in jaw or ringing in the ears?
- ❑ Yes ❑ No Any pain or soreness in the muscles of the face or around the ears?
- ❑ Yes ❑ No Difficulty in chewing or jaw opening?
- ❑ Yes ❑ No Any loose, broken, or missing fillings?
- ❑ Yes ❑ No Any teeth irritating cheek, lip, tongue or palate?
- ❑ Yes ❑ No Concerned about spaced, crooked or protruding teeth?
- ❑ Yes ❑ No Aware or concerned about under or over developed jaw?
- ❑ Yes ❑ No "Gum Boils," canker sores or cold sores?
- ❑ Yes ❑ No Taking any forms of fluoride?
- ❑ Yes ❑ No Any relative with similar tooth or jaw relationships?
- ❑ Yes ❑ No Had periodontal (gum) treatment?
- ❑ Yes ❑ No Would patient object to wearing orthodontic appliances (braces) should they be indicated?
- ❑ Yes ❑ No Any serious trouble associated with any previous dental treatment?

Name of Patient's Dentist: _____ Phone No. (_____) _____

Dentist's Address: _____ City: _____ State: _____ Zip_____

❑ Yes ❑ No Has the patient ever had a prior orthodontic examination or treatment?

Doctor's name: _____ Date of treatment: _____

What is your primary concern? Why are you here? _____

_____

I have read and understand the above questions. I will not hold my orthodontist or any member of his 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.

Signed: _____ Date signed: _____
(Parent or Guardian)

Signed: _____ Date signed: _____
(Dental Staff Member)