Medical Dental History Form
for Patients Under Age 18

CONFIDENTIA

PATIENT

Date _____

Patient's last name _____ First name _____ Middle initial_____

Prefers to be called _____ Hobbies, activities _____

Birth date _____ Sex: Male Female Email address(es) _____

School _____ Grade _____

Home address _____ City, State, Zip code _____

Home phone ( ) _____-_____ Cell phone ( ) _____-_____

PARENT/GUARDIAN

Custodial parent(s) name(s)_____

Patient lives with (circle all that apply) Mother Father Stepmother Stepfather Grandparent(s) Other _____

Father's full name _____ Title: Mr Dr Other_____

Social Security #_____ Date of Birth_____

Occupation_____ Email address_____

Address (if different) _____

Home Phone ( ) _____-_____ Cell phone ( ) _____-_____ Work phone ( ) _____-_____

Mother's full name_____ Title: Mrs Ms Dr Other_____

Social Security #_____ Date of Birth_____

Occupation_____ Email address _____

Address (if different) _____

Home Phone ( ) _____-_____ Cell phone ( ) _____-_____ Work phone ( ) _____-_____

GENERAL INFORMATION

What concerns you about your child's teeth?_____

What concerns your child about his/her 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?_____

Brother/sister name _____ age _____ had orthodontic treatment? Yes No If yes, where?_____

Brother/sister name _____ age _____ had orthodontic treatment? Yes No If yes, where?_____

Brother/sister name _____ age _____ had orthodontic treatment? Yes No If yes, where?_____

Have any other family members been treated in this office? Please name them._____

Whom can we thank for referring you to our practice? _____

DENTIST

Patient's Dentist _____ Address, City, State_____
Last seen _____ Reason _____ Next appointment _____
Other dentists/dental specialists now being seen: Name_____ City, State _____
Reason_____

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

PATIENT HEALTH INFORMATION

Do you think that any of your child's activities affect his/her 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 take antibiotic pre-medication before any dental procedures? _____
Does your child have (or ever had) a substance abuse problem? _____
Does your child chew or smoke tobacco? _____
Have you noticed any unusual changes in your child's face or jaws? _____
Any other physical problems?_____

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? _____
_____
How often does your child brush?_ _____ Floss? _____

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** _____

****NOTE**: Orthodontic Specialists, LLC will send a copy of your orthodontic treatment to your insurance company as a courtesy to you. Insurance payments may vary depending on your employer and your insurance policy. Please notify our office immediately of any changes to your insurance coverage, policy or employment.

AUTHORIZATIONS

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges to the extent permitted by law. I consent to your use and disclosure of protected health information to carry out payment activities in connection with this claim.

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, please mark yes, no, or don't know/understand (dk).

MEDICAL HISTORY

Now or in the past, has your child had:

Y N DK

- ☐ ☐ ☐ Birth defects or hereditary problems?
- ☐ ☐ ☐ Bone fractures or major injuries?
- ☐ ☐ ☐ Any injuries to face, head, neck?
- ☐ ☐ ☐ Arthritis or joint problems?
- ☐ ☐ ☐ Cancer, tumor, radiation treatment or
- ☐ ☐ ☐ 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?
- ☐ ☐ ☐ 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 had allergies or reactions to any of the following?

Y N DK

- ☐ ☐ ☐ 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:

Y N DK

- ☐ ☐ ☐ 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)?
- ☐ ☐ ☐ 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?

I have received a copy of this office's Notice of Privacy Practices.

Patient Name:_____

Patient or Responsible Party Signature:_____

Date:_____

You May Refuse to Sign This Acknowledgment

I agree that the orthodontic practice may communicate with me electronically at the email address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling 435-673-9661.

Email Address:_____@_____

Patient or Responsible Party Signature:_____

General Photography Release

I hereby authorize Orthodontic Specialists to publish photographs taken of me, or my child, for use in Orthodontic Specialists photo and video based marketing materials, as well as other company publications.

I hereby release and hold harmless Orthodontic Specialists from any reasonable expectation of privacy or confidentiality associated with the images specified above.

I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other company publications. I acknowledge and agree that publication of said photos confers no rights of ownership or royalties whatsoever.

I hereby release Orthodontic Specialists, and the employees involved in the creation or publication of marketing materials, from liability for any claims by me or any third party in connection with my participation.

Patient Name:_____

Responsible Party Signature:_____ Date_____