UNDER 18

WELCOME TO OUR OFFICE

MEDICAL DENTAL HISTORY FORM
UNDER 18

Date: _____ School: _____

Patient's Name: _____
LAST FIRST MIDDLE

Address: _____
STREET CITY STATE ZIP

Home Phone: _____ Birth Date: _____ Social Security #: _____

If patient is minor, give parent or guardian's name: _____

Patient Email: _____ Responsible Party Email: _____

Method of appointment reminder: ☐ Email ☐ Text: (_____)_____-_____/carrier: _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Marital Status: _____
LAST FIRST MIDDLE

Residence Address: _____
STREET CITY STATE ZIP

Mailing Address: _____
STREET/P.O. BOX CITY STATE ZIP

How long at this address: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ Alternate Phone: _____

Previous Address *(if less than 3 years)*: _____
STREET CITY STATE ZIP

Social Security #: _____ Birth Date: _____ Relationship to Patient: _____

Employer: _____ No. Years Employed: _____

Occupation: _____ Occupation No. _____
LAST FIRST MIDDLE

Spouse's Name: _____ Relationship to Patient: _____

Spouse's Employer: _____ Occupation No. _____ Years Employed: _____

Spouse's Social Security #: _____ Spouse's Birth Date: _____

INSURANCE INFORMATION

Insured's Name: _____ DOB: _____ Insured's Soc. Sec. #: _____

Insurance Company: _____ Group #: _____ Local No.: _____

Insurance Co. Address: _____

Do you have dual coverage?: ☐ Yes ☐ No If Yes, please continue:

Insured's Name: _____ Birth Date: _____ Insured's Soc. Sec. #: _____

Insurance Company: _____ Group #: _____ Local No.: _____

Insurance Co. Address: _____

Insured's Employer: _____

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____

Complete Address: _____

Phone: _____ Relationship to Patient: _____

Signature: _____ Date: _____

For the following questions mark yes, 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 examination.

Now or in the past, have you had:

☐ 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? If yes, Type I or Type II?
☐ yes ☐ no ☐ dk/u Cancer, tumor, radiation treatment or chemotherapy?
☐ yes ☐ no ☐ dk/u Stomach ulcer or hyperacidity?
☐ yes ☐ no ☐ dk/u Polio, mononucleosis, tuberculosis or 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 problem?
☐ yes ☐ no ☐ dk/u Fainting spells, seizures, epilepsy or neurological problem?
☐ yes ☐ no ☐ dk/u Mental health disturbance or behavioral problem?
☐ yes ☐ no ☐ dk/u Vision, hearing, tasting or speech difficulties?
☐ yes ☐ no ☐ dk/u Loss of weight recently, poor appetite?
☐ yes ☐ no ☐ dk/u History of eating disorder (anorexia, bulimia)?
☐ yes ☐ no ☐ dk/u Excessive bleeding or bruising 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 or swelling ankles?
☐ yes ☐ no ☐ dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
☐ yes ☐ no ☐ dk/u Skin disorder?
☐ yes ☐ no ☐ dk/u Does the patient eat a well-balanced diet?
☐ yes ☐ no ☐ dk/u Frequent headaches, colds or sore throats?
☐ yes ☐ no ☐ dk/u Eye, ear, nose or throat condition?
☐ yes ☐ no ☐ dk/u Tonsil or adenoid conditions?
☐ yes ☐ no ☐ dk/u Hayfever, asthma, sinus trouble?

Allergies or reactions to any of the following:

☐ yes ☐ no ☐ dk/u Latex (gloves, balloons)
☐ yes ☐ no ☐ dk/u Metals (jewelry, clothing snaps)
☐ yes ☐ no ☐ dk/u Local anesthetics, such as Lidocaine
☐ yes ☐ no ☐ dk/u Acrylic
☐ yes ☐ no ☐ dk/u Medications (please specify) _____
☐ yes ☐ no ☐ dk/u Foods (please specify) _____
☐ yes ☐ no ☐ dk/u Other substances (specify)_____
☐ yes ☐ no ☐ dk/u Are you taking medication, nutrient supplements, herbal medications or non-prescription medicine? If yes, please name them:
Medication_____ Taken for _____
Medication_____ Taken for _____
☐ yes ☐ no ☐ dk/u Does the patient currently have or ever had a substance abuse problem?
☐ yes ☐ no ☐ dk/u Does the patient smoke or chew tobacco?
☐ yes ☐ no ☐ dk/u Operations? Describe: _____
☐ yes ☐ no ☐ dk/u Hospitalized? For: _____
☐ yes ☐ no ☐ dk/u Being treated by another health care professional?
If yes, for: _____
☐ yes ☐ no ☐ dk/u Other physical problems or symptoms?
Describe: _____
Are there any other medical conditions (including family medical conditions) that we should be aware of? _____

Who may we thank for referring you to our office:

_____

General Dentist's Name: _____

Now or in the past, have you had:

☐ yes ☐ no ☐ dk/u Started teething very early or late?
☐ yes ☐ no ☐ dk/u Primary (baby) teeth removed that were not loose?
☐ yes ☐ no ☐ dk/u Permanent or "extra" (supernumerary) teeth removed?
☐ yes ☐ no ☐ dk/u Supernumerary (extra) or congenitally missing teeth?
☐ yes ☐ no ☐ dk/u Chipped or otherwise injured primary (baby) or permanent teeth?
☐ yes ☐ no ☐ dk/u Teeth sensitive to hot or cold; teeth throb or ache?
☐ yes ☐ no ☐ dk/u Jaw fractures, cysts or mouth infections?
☐ yes ☐ no ☐ dk/u "Dead teeth" or root canals treated?
☐ yes ☐ no ☐ dk/u Bleeding gums, bad taste or 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 or cold sores?
☐ yes ☐ no ☐ dk/u Thumb, finger, or sucking habit? Until what age? _____
☐ 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 or difficulty in breathing?
☐ yes ☐ no ☐ dk/u Tooth grinding, jaw clenching clicking or locking?
☐ yes ☐ no ☐ dk/u Any pain in jaw or ringing in the ears?
☐ yes ☐ no ☐ dk/u 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 or 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 Had periodontal (gum) treatment?
☐ yes ☐ no ☐ dk/u Had any serious trouble associated with any previous dental treatment?
☐ yes ☐ no ☐ dk/u Ever had a prior orthodontic examination or treatment?
☐ yes ☐ no ☐ dk/u Been under another dentist's care?
☐ yes ☐ no ☐ dk/u Been under another dental specialist's care?
☐ yes ☐ no ☐ dk/u Would patient object to wearing orthodontic appliances (braces) should they be indicated?

GIRLS ONLY

☐ yes ☐ no ☐ dk/u Has the patient started her monthly periods? If so, approximantely when? _____
☐ yes ☐ no ☐ dk/u Are you pregnant?

PATIENT PROFILE

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

I understand the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical history.

Signature: _____
Date: _____ Date: _____ Date: _____

Doctor: _____
Date: _____ Date: _____ Date: _____