

# 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. \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
LAST FIRST MIDDLE

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, approximately 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: \_\_\_\_\_