Lewis & Mansour ORTHODONTICS

# MEDICAL DENTAL HISTORY FORM
## FOR PATIENTS UNDER 18

## PATIENT INFORMATION

NAME: _____ (FIRST) _____ (M.I.) _____ (LAST) DATE: _____

PREFERS TO BE CALLED: _____ BIRTH DATE: ___/___/___ (MM DD YYYY) SEX: ☐ Male ☐ Female SSN: _____ (SOCIAL SECURITY NUMBER)

SCHOOL: _____ GRADE: _____

HOME ADDRESS: _____ (STREET) CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____) _____-_____ CELL PHONE: (_____) _____-_____ E-MAIL ADDRESS(ES): _____

## PARENT / GUARDIAN INFORMATION

CUSTODIAL PARENT(S) NAMES(S): _____

PATIENT LIVES WITH (*CHECK ALL THAT APPLY*): ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandparents ☐ Other _____

FATHER'S FULL NAME: _____ TITLE: ☐ Mr. ☐ Dr. ☐ Other _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____) _____-_____ CELL PHONE: (_____) _____-_____ E-MAIL ADDRESS(ES): _____

OCCUPATION: _____ EMPLOYER: _____ WORK PHONE: (_____) _____-_____

MOTHER'S FULL NAME: _____ TITLE: ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____) _____-_____ CELL PHONE: (_____) _____-_____ E-MAIL ADDRESS(ES): _____

OCCUPATION: _____ EMPLOYER: _____ WORK PHONE: (_____) _____-_____

## DENTIST

PATIENT'S DENTIST: _____ LAST SEEN: ___/___/___ (MM DD YYYY) REASON: _____

NEXT APPT: ___/___/___ (MM DD YYYY) ADDRESS: _____ (STREET) CITY: _____ STATE: _____

OTHER DENTISTS/DENTAL SPECIALISTS NOW BEING SEEN: _____ CITY: _____ STATE: _____

REASON FOR SEEING OTHER DENTIST/SPECIALIST: _____

## 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? _____

DOES YOUR CHILD PLAY A MUSICAL INSTRUMENT? _____

WHO SUGGESTED YOUR CHILD MIGHT NEED ORTHODONTIC TREATMENT? _____

WHY DID YOU CHOOSE OUR OFFICE? _____

HAS YOUR CHILD HAD ANY PREVIOUS ORTHODONTIC TREATMENT? PLEASE DESCRIBE _____

HAVE ANY OTHER FAMILY MEMBERS BEEN TREATED IN THIS OFFICE? PLEASE NAME THEM _____

## FINANCIAL RESPONSIBILITY

WHO IS FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT? _____ (FULL NAME) SSN: _____ (SOCIAL SECURITY NUMBER)

ADDRESS: _____ (STREET) CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____) _____-_____ CELL PHONE: (_____) _____-_____ E-MAIL ADDRESS(ES): _____

OCCUPATION: _____ EMPLOYER: _____ WORK PHONE: (_____) _____-_____



REVISION 1.0 - 20150220

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## DENTAL INSURANCE

**PRIMARY POLICY HOLDER** FULL NAME: _____ (FIRST) _____ (M.I.) _____ (LAST)

BIRTH DATE: ___/___/_____ (MM DD YYYY) SSN: _____ (SOCIAL SECURITY NUMBER) RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ (STREET) CITY: _____ STATE: _____ ZIP: _____

BEST PHONE: (_____)_____-_____ DOES THIS POLICY HAVE ORTHODONTIC BENEFITS? ☐ Yes ☐ No ☐ Don't Know

EMPLOYER: _____ EMPLOYER ADDRESS: _____ (STREET, CITY, STATE, & ZIP)

INSURANCE COMPANY: _____ GROUP #: _____ ID #: _____ PHONE: _____

**SECONDARY POLICY HOLDER** FULL NAME: _____ (FIRST) _____ (M.I.) _____ (LAST)

BIRTH DATE: ___/___/_____ (MM DD YYYY) SSN: _____ (SOCIAL SECURITY NUMBER) RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ (STREET) CITY: _____ STATE: _____ ZIP: _____

BEST PHONE: (_____)_____-_____ DOES THIS POLICY HAVE ORTHODONTIC BENEFITS? ☐ Yes ☐ No ☐ Don't Know

EMPLOYER: _____ EMPLOYER ADDRESS: _____ (STREET, CITY, STATE, & ZIP)

INSURANCE COMPANY: _____ GROUP #: _____ ID #: _____ PHONE: _____

## MEDICAL / DENTAL HISTORY

**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/U)*"**

### *MEDICAL HISTORY QUESTIONS: Now or in the past, have you had:*

☐ YES ☐ NO ☐ DK/U Birth defects or hereditary problems?
☐ YES ☐ NO ☐ DK/U Bone fractures, or major injuries?
☐ YES ☐ NO ☐ DK/U Any injuries to face, head, neck?
☐ YES ☐ NO ☐ DK/U Arthritis or joint problems?
☐ YES ☐ NO ☐ DK/U Endocrine or thyroid problems?
☐ YES ☐ NO ☐ DK/U Diabetes or low sugar?
☐ YES ☐ NO ☐ DK/U Kidney problems?
☐ YES ☐ NO ☐ DK/U Cancer, tumor, radiation treatment or chemotherapy?
☐ YES ☐ NO ☐ DK/U Stomach ulcer, hyperacidity, acid reflux?
☐ YES ☐ NO ☐ DK/U Immune system problems?
☐ YES ☐ NO ☐ DK/U History of osteoporosis?
☐ YES ☐ NO ☐ DK/U Gonorrhea, syphilis, herpes, sexually transmitted diseases?
☐ YES ☐ NO ☐ DK/U AIDS or HIV positive?
☐ YES ☐ NO ☐ DK/U Hepatitis, jaundice or other liver problem?
☐ YES ☐ NO ☐ DK/U Polio, mononucleosis, tuberculosis, pneumonia?
☐ YES ☐ NO ☐ DK/U Seizures, fainting spells, neurologic problem?
☐ YES ☐ NO ☐ DK/U Mental health disturbance or depression?
☐ YES ☐ NO ☐ DK/U History of eating disorder (anorexia, bulimia)?
☐ YES ☐ NO ☐ DK/U Excessive bleeding or bruising, anemia?
☐ YES ☐ NO ☐ DK/U Heart defects, heart murmur, rheumatic heart disease?
☐ YES ☐ NO ☐ DK/U Angina, arteriosclerosis, stroke or heart attack?
☐ YES ☐ NO ☐ DK/U Frequent headaches or migraines?
☐ YES ☐ NO ☐ DK/U Asthma, sinus problems, hayfever?
☐ YES ☐ NO ☐ DK/U Tonsilar adenoid condition?
☐ YES ☐ NO ☐ DK/U Has your child ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?
☐ YES ☐ NO ☐ DK/U Has your child ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders?

### *DENTAL HISTORY QUESTIONS: Now or in the past, have you had:*

☐ YES ☐ NO ☐ DK/U Erupting teeth very early or very 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 injured primary or permanent teeth?
☐ YES ☐ NO ☐ DK/U Any sensitive or sore teeth?
☐ YES ☐ NO ☐ DK/U Any lost or broken fillings?
☐ YES ☐ NO ☐ DK/U Jaw fractures, cysts, infections?
☐ YES ☐ NO ☐ DK/U Any teeth treated with root canals or pulpotomies?
☐ YES ☐ NO ☐ DK/U "Gum boils," frequent canker sores, or cold sores?
☐ YES ☐ NO ☐ DK/U History of speech problems or speech therapy?
☐ YES ☐ NO ☐ DK/U Difficulty breathing through nose?
☐ YES ☐ NO ☐ DK/U Mouth breathing habit or snoring at night?
☐ YES ☐ NO ☐ DK/U History of gum recession or bone loss?
☐ YES ☐ NO ☐ DK/U Frequent oral habits (sucking finger, chewing pen, etc.)?
☐ YES ☐ NO ☐ DK/U Teeth causing irritation to lip, cheek or gums?
☐ YES ☐ NO ☐ DK/U Tooth grinding or clenching?
☐ YES ☐ NO ☐ DK/U Clicking, locking in jaw joints?
☐ YES ☐ NO ☐ DK/U Soreness in jaw muscles or face muscles?
☐ YES ☐ NO ☐ DK/U Has your child ever been treated for "TMJ" or "TMD" problems?
☐ YES ☐ NO ☐ DK/U Any serious trouble associate with previous dental treatment?
☐ YES ☐ NO ☐ DK/U Has your child ever been diagnosed with gum disease or pyorrhea?

### *ALLERGY QUESTIONS: Have you had allergies or reactions to any of the following?*

☐ YES ☐ NO ☐ DK/U Local anesthetics (novocaine, lidocaine, xylocaine)
☐ YES ☐ NO ☐ DK/U Latex (gloves, balloons)
☐ YES ☐ NO ☐ DK/U Aspirin
☐ YES ☐ NO ☐ DK/U Ibuprofen (Motrin, Advil)
☐ YES ☐ NO ☐ DK/U Penicillin
☐ YES ☐ NO ☐ DK/U Other antibiotics
☐ YES ☐ NO ☐ DK/U Metals (jewelry, clothing snaps)
☐ YES ☐ NO ☐ DK/U Acrylics
☐ YES ☐ NO ☐ DK/U Other substances _____



REVISION 1.0 - 20150220

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## 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, AND/OR NON-PRESCRIPTION MEDICINES, INCLUDING FLUORIDE SUPPLEMENTS THAT YOUR CHILD TAKES

MEDICATION: _____ TAKEN FOR: _____

MEDICATION: _____ TAKEN FOR: _____

MEDICATION: _____ TAKEN FOR: _____

HAS YOUR CHILD EVER TAKEN ANY MEDICATIONS TO STRENGTHEN HIS/HER BONES? PLEASE DESCRIBE _____

DOES YOUR CHILD TAKE ANTIBIOTIC PRE-MEDICATION BEFORE ANY DENTAL PROCEDURES? ☐ Yes ☐ No

DOES YOUR CHILD CURRENTLY HAVE (OR HAS YOUR CHILD EVER HAD) A SUBSTANCE ABUSE PROBLEM? _____

DOES YOUR CHILD CHEW OR SMOKE TOBACCO? _____

HAVE YOU NOTICED ANY CHANGES IN YOUR CHILD'S FACE OR JAWS? _____

ANY OTHER PHYSICAL PROBLEMS? _____

HOW OFTEN DOES YOUR CHILD BRUSH? _____

HOW OFTEN DOES YOUR CHILD FLOSS? _____

## 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? _____

## RELEASE AND WAIVER

*I authorize release of any information regarding my 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 medical or dental health.*

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____



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