American Association of Orthodontists®
My Life. My Smile. My Orthodontist.®

MEDICAL DENTAL HISTORY FORM FOR PATIENTS UNDER AGE 18

CONFIDENTIAL

PATIENT

Date_____

Patient's Last Name_____ First Name_____ Middle Int. _____

Prefers to be called _____ Birth Date _____ Age ___ ☐Male ☐Female

School _____ Grade_____

Home address _____ City, State, Zip_____

Home phone ( ) _____

PARENT/GUARDIAN

Custodial Parent(s) Name(s)_____

Patient lives with (check all that apply) ☐Mother and Father in same household

☐Mother ☐Father ☐Stepmother ☐Stepfather ☐Grandparents ☐Other

Father's Full Name_____ Title ☐Mr ☐Dr ☐Other_____

Occupation_____ Email Address_____

Address (if different) _____

Hm phone (if different)☐( )_____ Cell phone ☐( )_____ Work Phone ☐( )_____

(Please check the number you prefer we use for contacting you)

Mother's Full Name _____ Title ☐Mrs ☐Ms ☐Dr ☐Other_____

Occupation_____ Email Address_____

Address (if different) _____

Hm phone (if different) ☐( )_____ Cell phone ☐( )_____ Work Phone ☐( )_____

(Please check the number you prefer we use for contacting you)

DENTIST

Patient's Dentist_____ City, State_____

Last seen _____ Reason_____

GENERAL INFORMATION

What concerns you about your child's teeth?_____

Why did you select our office/ Who referred you to our office? _____

Any previous orthodontic treatment or consultations?_____

Have any other family members been treated in this office? Please name them_____

FINANCIAL RESPONSIBILITY

Who is financially responsibility for this account?_____

Address (if different than page 1) _____ City, State, Zip _____

DENTAL INSURANCE

Please provide your insurance card to the front desk person

Primary policy holder's full name_____ Birth Date_____

Insurance company_____ Relationship to patient_____

Social Security # or Insurance Subscriber ID#_____

Secondary policy holder's full name _____ Birth Date_____

Insurance company_____ Relationship to patient_____

Social Security # or Insurance Subscriber ID#_____

PHYSICIAN

Patient's Physician_____ City, State, Zip _____

Last seen_____ Reason _____ Next appointment _____

Most recent physical exam_____

PATIENT HEALTH INFORMATION

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?_____

Have you noticed any unusual changes in your child's face or jaws?_____

MEDICAL HISTORY

Now or in the past, have you had:

Yes	No	DK/U	
☐	☐	☐	Birth defects or hereditary problems?
☐	☐	☐	Heart defects, heart murmur, rheumatic heart disease?
☐	☐	☐	Any injuries to the face, head, neck?
☐	☐	☐	Arthritis or joint problems?
☐	☐	☐	Endocrine or thyroid problems?
☐	☐	☐	Diabetes or low blood sugar?
☐	☐	☐	Kidney problems?
☐	☐	☐	Cancer, tumor, radiation treatment or chemotherapy?
☐	☐	☐	Stomach ulcer, hyperacidity, acid reflux?
☐	☐	☐	Immune system problems?
☐	☐	☐	AIDS or HIV positive?
☐	☐	☐	Hepatitis, jaundice, or other liver problems?
☐	☐	☐	Polio, mononucleosis, tuberculosis, pneumonia?
☐	☐	☐	Seizures, fainting spells, neurologic problems?
☐	☐	☐	Mental health disturbance or depression?
☐	☐	☐	Vision, hearing, or speech problems?
☐	☐	☐	History of eating disorder (anorexia, bulimia)?
☐	☐	☐	High or low blood pressure?
☐	☐	☐	Excessive bleeding or bruising, anemia?
☐	☐	☐	Skin disorder (other than common acne)?
☐	☐	☐	Frequent headaches or migraines?
☐	☐	☐	Frequent ear infections, colds, throat infections?
☐	☐	☐	Asthma, sinus problems, hayfever?
☐	☐	☐	Tonsil or adenoid condition?
☐	☐	☐	Do you frequently breathe through your mouth?
☐	☐	☐	Has your child ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?
☐	☐	☐	Has your child ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate)

Have you had allergies or reactions to any of the following:

Yes	No	DK/U	
☐	☐	☐	Local anesthetics (novocaine, lidocaine, xylocaine)
☐	☐	☐	Latex (gloves, balloons)
☐	☐	☐	Aspirin
☐	☐	☐	Metals (jewelry, clothing snaps)
☐	☐	☐	Penicillin
☐	☐	☐	Other antibiotics
☐	☐	☐	Ibuprofen (Motrin, Advil)
☐	☐	☐	Acrylics
☐	☐	☐	Foods
☐	☐	☐	Other substances_____

DENTAL HISTORY

Now or in the past, have you had:

Yes	No	DK/U	
☐	☐	☐	Supernumerary (extra) or congenitally missing teeth?
☐	☐	☐	Any teeth treated with root canals or pulpotomies?
☐	☐	☐	History of speech problems or speech therapy?
☐	☐	☐	Difficulty breathing through nose?
☐	☐	☐	Mouth breathing habit or snoring at night?
☐	☐	☐	Frequent oral habits (sucking finger, chewing pen, etc)?
☐	☐	☐	Tooth grinding or clenching?
☐	☐	☐	Clicking, locking in jaw joints?
☐	☐	☐	Any serious trouble associated with previous dental treatment?

☐ ☐ ☐ **Other medical problems? Please explain:**

_____

_____

_____

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

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.

Signature _____ Date _____