BRACESETTERS

MEDICAL DENTAL HISTORY FORM FOR PATIENTS UNDER 18 YEARS OF AGE

Date _____ Doctor_____ Office_____

Patient's Last Name: _____ First Name: _____ M. I.: _____

Birth Date: _____ Age: _____ Sex: Male □ Female □ I prefer to be called: _____

Social Security No.: _____ Home Telephone No.: _____

Patient's Address:_____

City:_____ State: _____ Zip Code: _____

Attends School at: _____ Grade: _____

Musical Instruments Played: _____

Sports and/or Hobbies:_____

Number of brothers and sisters: _____ Ages: _____

Other family members treated by Bracesetters:_____

Birth Father's Height: _____ ft. _____ in. Birth Mother's Height: _____ft. _____in.

Patient's Birth Weight: _____lbs. _____oz. Patient's present Weight: _____lbs. Patient's present Height: _____ft. _____in.

Custodial Parent(s) or Guardian(s): _____

Social Security Numbers: _____ _____

Telephone No. (if different from patient's): _____

Address (if different form patient's): _____City:_____ State: _____ Zip Code: _____

E-mail Address: _____ Cell Phone/Pager: _____

Name of Patient's Dentist: _____ Telephone No.: _____

Dentist's Address: _____ City:_____ State: _____ Zip Code: _____

Date Last Seen By Dentist: _____ Reason: _____

Name of Patient's Physician: _____ Telephone No.: _____

Physicians Address: _____City: _____ State: _____ Zip Code: _____

Date Last Seen By Physician: _____ Reason: _____

Who is Financially Responsible for this Account?

Last Name: _____ First Name: _____ M.I. _____

Address (if different from patient's) _____

City: _____ State: _____ Zip Code: _____ Yrs. at this Address _____

Telephone No. (if different from Patient's) _____ Social Security No.: _____

Employer: _____ How many years? _____

Employer's address: _____City:_____ State:_____ Zip: _____

Insurance coverage for dental treatment? Yes □ No □ Insurance coverage for orthodontic treatment? Yes □ No □

Primary Policy Holder's Name: _____ Social Security No.: _____

Birth Date: _____ Employed by: _____

Dental Insurance Company: _____ Group No.: _____

Secondary Policy Holder's Name: _____ Social Security No.: _____

Birth Date: _____ Employed by: _____

Dental Insurance Company: _____ Group No.:_____

Who suggested that your child might need orthodontic treatment? _____

Why did you select our office? _____

For the following questions mark yes, no or don't know (dk). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

PATIENT PROFILE

- ☐ Yes ☐ No ☐ dk Does patient follow directions well?
- ☐ Yes ☐ No ☐ dk Does patient brush his/her teeth conscientiously?
- ☐ Yes ☐ No ☐ dk Does patient have learning disabilities or need extra help with instructions?
- ☐ Yes ☐ No ☐ dk Is patient sensitive or self-conscience about his/her teeth?

MEDICAL HISTORY

Now or in the past has patient had:

- ☐ Yes ☐ No ☐ dk Birth defects or hereditary problems?
- ☐ Yes ☐ No ☐ dk Bone fractures, any major accidents?
- ☐ Yes ☐ No ☐ dk Rheumatoid or arthritic conditions?
- ☐ Yes ☐ No ☐ dk Endocrine or thyroid problems?
- ☐ Yes ☐ No ☐ dk Kidney problems?
- ☐ Yes ☐ No ☐ dk Diabetes?
- ☐ Yes ☐ No ☐ dk Cancer, tumor, radiation treatment or chemotherapy?
- ☐ Yes ☐ No ☐ dk Stomach ulcer or hyperacidity?
- ☐ Yes ☐ No ☐ dk Polio, mononucleosis, tuberculosis, pneumonia?
- ☐ Yes ☐ No ☐ dk Problems of the immune system?
- ☐ Yes ☐ No ☐ dk AIDS or HIV positive?
- ☐ Yes ☐ No ☐ dk Hepatitis, jaundice or liver problem?
- ☐ Yes ☐ No ☐ dk Fainting spells, seizures, epilepsy or neurological problem?
- ☐ Yes ☐ No ☐ dk Mental health disturbance or depression?
- ☐ Yes ☐ No ☐ dk Vision, hearing, tasting or speech difficulties?
- ☐ Yes ☐ No ☐ dk Loss of weight recently, poor appetite?
- ☐ Yes ☐ No ☐ dk History of eating disorder (anorexia, bulimia)?
- ☐ Yes ☐ No ☐ dk Excessive bleeding or bruising tendency, anemia or bleeding disorder?
- ☐ Yes ☐ No ☐ dk High or low blood pressure?
- ☐ Yes ☐ No ☐ dk Tired easily?
- ☐ Yes ☐ No ☐ dk Chest pain, shortness of breath or swelling of ankles?
- ☐ Yes ☐ No ☐ dk Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?

Now or in the past has patient had:

- ☐ Yes ☐ No ☐ dk Skin disorder?
- ☐ Yes ☐ No ☐ dk Does the patient eat a well balanced diet?
- ☐ Yes ☐ No ☐ dk Frequent headaches, colds or sore throats?
- ☐ Yes ☐ No ☐ dk Eye, ear, nose or throat condition?
- ☐ Yes ☐ No ☐ dk Hayfever, asthma, sinus trouble or hives?
- ☐ Yes ☐ No ☐ dk Tonsil or adenoid conditions?

Allergies or reactions to any of the following:

- ☐ Yes ☐ No ☐ dk Local anesthetics (Novocaine or Lidocaine)
- ☐ Yes ☐ No ☐ dk Aspirin
- ☐ Yes ☐ No ☐ dk Ibuprofen (Motrin, Advil)
- ☐ Yes ☐ No ☐ dk Penicillin or other antibiotics
- ☐ Yes ☐ No ☐ dk Sulfa drugs
- ☐ Yes ☐ No ☐ dk Codeine or other narcotics
- ☐ Yes ☐ No ☐ dk Metals (jewelry, clothing snaps)
- ☐ Yes ☐ No ☐ dk Latex (gloves, balloons)
- ☐ Yes ☐ No ☐ dk Vinyl
- ☐ Yes ☐ No ☐ dk Acrylic
- ☐ Yes ☐ No ☐ dk Animals
- ☐ Yes ☐ No ☐ dk Foods (specify) _____ _____
- ☐ Yes ☐ No ☐ dk Other substances (specify) _____ _____

☐ Yes ☐ No ☐ dk Is the patient taking medication, nutrient supplements, herbal medications or non-prescription medicine. Please name them:

Medication_____ Taken for _____

Medication_____ Taken for _____

Medication_____ Taken for _____

☐ Yes ☐ No ☐ dk Does the patient currently have or ever had a substance abuse problem?

☐ Yes ☐ No ☐ dk Does the patient chew or smoke tobacco?

☐ Yes ☐ No ☐ dk Operations? Describe _____

☐ Yes ☐ No ☐ dk Hospitalized? Describe _____

☐ Yes ☐ No ☐ dk Other physical problems or symptoms? Describe_____

☐ Yes ☐ No ☐ dk Being treated by another health care professional? For: _____ Date of most recent physical exam _____

□ Yes □ No □ dk Has patient ever been told by a physician that he/she requires pre-medication with antibiotics for dental visits?

FAMILY MEDICAL HISTORY

Do the patient's parents or siblings have any of the following health problems? If so, please explain.

Bleeding disorder_____ Diabetes_____ Arthritis_____

Metabolic disturbances_____ Severe allergies_____

Unusual dental problems _____ Jaw size imbalance _____

Any other family medical conditions that we should know about? _____

GIRLS ONLY

□ yes □ No □ dk Has the patient started her monthly periods? If so, approximately when? _____
□ Yes □ No □ dk Is the patient pregnant?

DENTAL HISTORY

Now or in the past, has the patient had:

□ Yes □ No □ dk Started teething very early or late?
□ Yes □ No □ dk Difficulty chewing or opening jaw?
□ Yes □ No □ dk Tooth grinding or jaw clenching?
□ Yes □ No □ dk Any pain, clicking or locking in jaw or ringing in ears?
□ Yes □ No □ dk Any pain or soreness in the muscles of the face or around the ears?
□ Yes □ No □ dk Treatment for TDM or TMJ problems?
□ Yes □ No □ dk Chipped or otherwise injured primary or permanent teeth?
□ Yes □ No □ dk Any teeth irritating cheek, lip, tongue or palate?
□ Yes □ No □ dk Permanent or "extra" (supernumerary) teeth removed?
□ Yes □ No □ dk Supernumerary (extra) or congenitally missing teeth?
□ Yes □ No □ dk Primary (baby) teeth removed that were not loose?
□ Yes □ No □ dk Abnormal swallowing habit (tongue thrusting)?
□ Yes □ No □ dk Thumb, finger or sucking habit? Until what age? _____
□ Yes □ No □ dk Mouth breathing habit, snoring or difficulty in breathing?
□ Yes □ No □ dk Aware of loose, broken or missing restorations (fillings)?
□ Yes □ No □ dk Any serious trouble associated with any previous dental treatment?
□ Yes □ No □ dk Would the patient object to wearing orthodontic appliances (braces) should they be indicated?
□ Yes □ No □ dk Ever had a prior orthodontic examination or treatment?

□ Yes □ No □ dk Food impaction between teeth?
□ Yes □ No □ dk Jaw fractures or other trauma to face?
□ Yes □ No □ dk Cysts or mouth infections?
□ Yes □ No □ dk "Gum boils", canker sores or cold sores?
□ Yes □ No □ dk Periodontal (gum) problems?
□ Yes □ No □ dk Had periodontal (gum) treatment?
□ Yes □ No □ dk History of speech problems?
□ Yes □ No □ dk Teeth sensitive to hot or cold?
□ Yes □ No □ dk Teeth that throb or ache?
□ Yes □ No □ dk "Dead" teeth or root canals treated?
□ Yes □ No □ dk Taking any forms of fluoride?
□ Yes □ No □ dk Been under another dentist's care?
Specialist _____
Other_____
□ Yes □ No □ dk Is patient wearing any removal dental appliances? Is so, what are they?_____

How often does the patient brush:_____ Floss:_____

What is your primary concern? Why are you here?_____

□ Yes □ No □ dk Concerns about spaced, crooked or protruding teeth?
□ Yes □ No □ dk Concerns about under or over developed jaw(s)

I have read and understand the above questions. 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. If there are any changes later to this history record or medical/dental status, I will inform Bracesetters.

Signed:_____ Date Signed:_____
(Parent or Guardian)

I hereby acknowledge that I have received and reviewed a copy of the Bracesetters' Privacy Notice.

Signed:_____ Date Signed:_____