MEDICAL DENTAL HISTORY FORM FOR PATIENTS UNDER AGE 18

PATIENT INFORMATION – Under Age 18

Patient Name: _____ ☐ Male ☐ Female

Social Security # _____ Birth Date: _____ Age: _____

Cell #: _____ Home #: _____ Work #: _____

Email: _____

Address: _____
Street Apartment #

_____
City State Zip

School: _____ Grade: _____ Hobbies: _____

PARENT / GUARDIAN

Custodial Parent(s) Name(s): _____

Patient lives with *(check all that apply)*: ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandparent(s) ☐ Other _____

Father's Full Name: _____ Birth Date: _____

Is this person Financially Responsible for Patient's Account? ☐ **YES** ☐ **NO**

Occupation: _____ Employer Name & Address: _____

Social Security # _____

Cell #: _____ Home #: _____ Work #: _____

Email: _____

Address (if different from Patient): _____
Street Apartment #

_____
City State Zip

Mother's Full Name: _____ Birth Date: _____

Is this person Financially Responsible for Patient's Account? ☐ **YES** ☐ **NO**

Occupation: _____ Employer Name & Address: _____

Social Security # _____

Cell #: _____ Home #: _____ Work #: _____

Email: _____

Address (if different from Patient): _____
Street Apartment #

_____
City State Zip

Other's Full Name: _____ Birth Date: _____

Is this person Financially Responsible for Patient's Account? ☐ **YES** ☐ **NO** Relationship to Patient: _____

Occupation: _____ Employer Name & Address: _____

Social Security # _____

Cell #: _____ Home #: _____ Work #: _____

Email: _____

Address (if different from Patient): _____
Street Apartment #

_____
City State Zip

GENERAL INFORMATION

Does Patient play a musical instrument? _____

Have any other family members been treated at DFC Orthodontics? Please name them. _____

Brother/Sister Name: _____ Age: _____ Had Orthodontic Treatment? ☐ YES ☐ NO If Yes, where? _____

Brother/Sister Name: _____ Age: _____ Had Orthodontic Treatment? ☐ YES ☐ NO If Yes, where? _____

Brother/Sister Name: _____ Age: _____ Had Orthodontic Treatment? ☐ YES ☐ NO If Yes, where? _____

Brother/Sister Name: _____ Age: _____ Had Orthodontic Treatment? ☐ YES ☐ NO If Yes, where? _____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Newspaper ☐ School ☐ Work ☐ Other: _____

Name of person or office referring you to our practice: _____

DENTAL INSURANCE INFORMATION

Primary Policy Holder's Full Name: _____ Birth Date: _____

Social Security #: _____ Relationship to Pt: _____

Dental Ins Co: _____

Group # _____ ID # _____

Policy Holder's Employer: _____

Secondary Policy Holder's Full Name: _____ Birth Date: _____

Social Security #: _____ Relationship to Pt: _____

Dental Ins Co: _____

Group # _____ ID # _____

Policy Holder's Employer: _____

RELEASE AND WAIVER

1) I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis.
2) Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3) I agree to the use of topical anesthetics as necessary. I fully understand that using anesthetic agents embodies a certain risk.
4) I agree to be responsible for payment of all services on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a $25 late charge may be added to my account.
5) I hereby give DFC Orthodontics the absolute right and permission to use my photographs/slides for educational or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said photographs/slides.
6) I authorize release of any information regarding Patient's orthodontic treatment to Patient's dental and/or medical insurance company.

Signature of Parent / Guardian	Print Name	Date

DENTAL HISTORY – UNDER AGE 18

Name of Dentist? _____ Dentist's Phone #: _____

Date of Last Cleaning/Examination: _____ How often does Patient have a Dental Cleaning/Exam? _____

1. Has Patient ever had orthodontic treatment or consult? ☐Yes ☐No If yes, when & where? _____
2. Has Patient ever seen a periodontist or been treated for gum disease? ☐Yes ☐No If yes, when & where? _____
3. Has Patient's bite ever been adjusted? ☐Yes ☐No
4. Are Patient's teeth sensitive? ☐Yes ☐No
5. Does/Did Patient suck thumb? ☐Right ☐Left Does habit continue? ☐Yes ☐No *OR* What age did habit stop? _____
6. Does Patient ☐ clench or ☐ grind his/her teeth? If checked, does Patient do this: ☐All the time ☐Only at night ☐Only when nervous/stressed
7. Do Patient's gums bleed? ☐Yes ☐No If yes, do gums bleed: ☐All the time ☐Occasionally
8. Has Patient noticed any mouth odors or bad tastes? ☐Yes ☐No
9. Does food tend to become caught between Patient's teeth? ☐Yes ☐No
10. Does Patient have clicking or popping in his/her jaw? ☐Yes ☐No
11. Does Patient have difficulty opening or closing his/her mouth? ☐Yes ☐No
12. Has Patient been told h/she has a TMJ problem? ☐Yes ☐No
13. Does Patient get frequent headaches? ☐Yes ☐No
14. Would Patient like to keep his/her teeth all his/her life? ☐Yes ☐No
15. Has Patient noticed any loose teeth or change in his/her bite? ☐Yes ☐No If yes, please explain: _____
16. Has Patient ever had an injury to the face or teeth? ☐Yes ☐No If yes, please explain: _____
17. Does Patient feel nervous about having dental treatment? ☐Yes ☐No If yes, please explain: _____
18. Has Patient ever had an upsetting dental experience? ☐Yes ☐No If yes, please explain: _____
19. Has Patient had any complications following dental treatment? ☐Yes ☐No If yes, please explain: _____
20. Is Patient happy with the appearance of his/her teeth? ☐Yes ☐No If no, please explain: _____

MEDICAL INFORMATION – UNDER AGE 18

Name of Physician? _____ Physician's Phone #: _____

Has Patient ever had any of the following? Please check all that apply:

☐ AIDS	☐ Artificial Joints	☐ Excessive Bleeding	☐ Hepatitis	☐ Pre-Medication Required	☐ Stomach Problems
☐ Allergy to Latex	☐ Asthma	☐ Fainting	☐ High Blood Pressure	☐ Pregnancy	☐ Stroke
☐ Allergy to Nickel	☐ Blood Disease	☐ Glaucoma	☐ HIV	Due Date: _____	☐ Tuberculosis
☐ Allergy to Plastic	☐ Bone Disorders	☐ Growths/Cysts	☐ Jaundice	☐ Radiation Treatment	☐ Tumors
☐ Allergy to Codeine	☐ Cancer	☐ Hay Fever	☐ Kidney Disorders	☐ Respiratory Problems	☐ Ulcers
☐ Allergy to Penicillin	☐ Diabetes	☐ Head Injuries	☐ Liver Disease	☐ Rheumatic Fever	☐ Venereal Disease
☐ Anemia	☐ Dizziness	☐ Heart Disease	☐ Mental Disorders	☐ Rheumatism	☐ _____
☐ Arthritis	☐ Epilepsy	☐ Heart Murmur	☐ Pacemaker	☐ Sinus Problems	☐ _____

Please List All Medications: _____

1. Has Patient ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer? ☐Yes ☐No
2. Has Patient ever taken oral bisphosphonates such as Fosamax (aledronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders? ☐Yes ☐No
3. Has Patient ever been admitted to a hospital or needed emergency care during the past two years? ☐Yes ☐No If yes, please explain: _____
4. Is Patient now under the care of a physician? ☐Yes ☐No If yes, please explain: _____
5. Does Patient have any health problems that need further clarification? ☐Yes ☐No If yes, please explain: _____

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 orthodontist of any change in Patient's medical or dental health.

Signature of Parent / Guardian	Print Name	Date