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

Medical Dental History Form for Patients Under Age 18

CONFIDENTIAL
Patient with: _____
Patient #:_____
Appt Date:_____

PATIENT

Patient Name _____ Prefers to be called _____
Date of Birth _____ **M F** Age _____ School Patient attends _____ Grade _____
Address _____ City _____ Zip _____
Names and ages of children in family _____
Family members in our orthodontic practice _____

PATIENT PARENT/GUARDIAN

MOTHER/GUARDIAN NAME_____ Date of Birth: _____
Marital Status: Single Married Divorced Separated Spouse's Name _____
Address *(if different)*_____
Home Phone ( )_____-_____ Cell Phone ( )_____-_____ Work Phone ( )_____-_____
Email _____
Employed By _____ Occupation _____
If Guardian, relationship to child _____
FATHER/GUARDIAN NAME _____ Date of Birth: _____
Marital Status: Single Married Divorced Separated Spouse's Name _____
Address *(if different)*_____
Home Phone ( )_____-_____ Cell Phone ( )_____-_____ Work Phone ( )_____-_____
Email _____
Employed By _____ Occupation _____
If Guardian, relationship to child _____
Patient lives with (circle all that apply) Mother Father Stepmother Stepfather Grandparents Other _____

DENTAL INSURANCE

Do you have Dental Insurance? Yes No If yes, is there an orthodontic benefit? Yes No Don't Know
****Please provide your insurance information if not given prior to your appointment.**

DENTIST

Patient's Dentist Name _____
Date last seen _____
Name of other dentists/dental specialists seen _____
Reason _____

GENERAL INFORMATION

What is your main concern about your child's teeth? _____
How often does your child brush?_____ How often does your child floss? _____
Who referred your child to our office? _____
Who suggested that your child might need orthodontic treatment? _____
Describe any previous orthodontic treatment or consultations. _____

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 _____
Has your child ever taken any medications to strengthen your bones? Please describe _____
Does your child take antibiotic pre-medication before any dental procedures? _____
Does your child chew or smoke tobacco? _____
Is there anything else we need to know about your child that would help us make you feel more comfortable during your time here in the office?
_____
_____

Child form 2nd page

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*

MEDICAL HISTORY

Now or in the past, has your child had :

Yes	No	DK	
◯	◯	◯	If female, is your child pregnant?
◯	◯	◯	Any injuries to face, head, neck?
◯	◯	◯	Arthritis or joint problems?
◯	◯	◯	Cancer, tumor, radiation treatment or chemotherapy?
◯	◯	◯	Diabetes or low sugar?
◯	◯	◯	History of osteoporosis?
◯	◯	◯	Birth defects or hereditary Problems?
◯	◯	◯	Frequent headaches or migraines?
◯	◯	◯	High or low blood pressure?
◯	◯	◯	Excessive bleeding or bruising, anemia?
◯	◯	◯	Heart defects, heart murmur, rheumatic heart disease?
◯	◯	◯	Angina, Arteriosclerosis, stroke or heart attack?
◯	◯	◯	Stomach ulcer, hyperacidity, acid reflux?
◯	◯	◯	Chest pain, shortness of breath, tire easily, swollen ankles?
◯	◯	◯	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) for bone disorders**?**

Has your child had allergies or reactions to any of the following?

Yes	no	DK	
◯	◯	◯	**Latex (gloves, balloons)**
◯	◯	◯	Medications _____
◯	◯	◯	Metals (jewelry, clothing snaps)
◯	◯	◯	Acrylics
◯	◯	◯	Foods Type _____

DENTAL HISTORY

Now or in the past, has your child had:

Yes	no	DK	
◯	◯	◯	Bleeding gums?
◯	◯	◯	Food impaction between teeth?
◯	◯	◯	Permanent or extra (supernumerary) teeth removed?
◯	◯	◯	Supernumerary (extra) or congenitally missing teeth?
◯	◯	◯	Chipped or injured primary or permanent teeth?
◯	◯	◯	Any sensitive or sore teeth?
◯	◯	◯	Any broken or missing fillings?
◯	◯	◯	Jaw fractures, cysts, infections?
◯	◯	◯	Any teeth treated with root canals or pulpotomies?
◯	◯	◯	History of speech problem or speech therapy?
◯	◯	◯	Finger sucking or thumb sucking?
◯	◯	◯	Tooth grinding or clenching?
◯	◯	◯	Ringing in ears, difficulty in chewing or opening jaw?
◯	◯	◯	Clicking, locking in jaw joints?
◯	◯	◯	Soreness in jaw muscles or face muscles?
◯	◯	◯	Has your child ever been treated for "TMJ" or "TMD" Problems?
◯	◯	◯	Has your child ever seen a periodontist or gum specialist?

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical Insurance company and to send letters or communicate verbally with my dentist and /or dental specialists. I hereby give my permission for the use of orthodontic records, including photographs, made in the process of examinations, treatment, and retention for purposes of professional consultations, research or education.

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 _____