

Registration and Medical History –**Minor**

Consult Date _____

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

Preferred name/nickname _____

Birth Date _____ Age _____ Sex: M / F _____

Home Phone _____

Complete Home Address _____

Attends School At _____ Grade _____

Sports/Hobbies _____ Musical Instruments _____

Siblings/Ages: _____

Family members treated here _____

Custodial Parent(s)/Guardian(s) _____

Address (if different than patient's) _____

Phone (if different than patient's) _____ Cell _____

E-mail _____

Name of Patient's **Dentist** _____ Phone _____

Date last seen _____ Reason _____

Who suggested that your child might need orthodontic treatment? _____

Why did you select our office? _____

Who Is **Financially** Responsible For This Account? _____

Last Name _____ First Name _____ M.I. _____

Address (if different than patient's) _____

MEDICAL HISTORY: Answer every question by circling Y (yes) N (no) U (unsure).

Was the patient ever diagnosed with the following?: Taking medications for?(list)

Y N U Birth defects or hereditary problem?

Y N U Bone fractures or major accident?

Y N U Rheumatoid or arthritic conditions?

Y N U Endocrine or thyroid problems?

Y N U Kidney problems?

Y N U Diabetes?

Y N U Cancer, tumor, radiation or chemo treatment?

Y N U Stomach ulcer or hyperacidity?

Y N U Polio, mononucleosis, tuberculosis or pneumonia?

Y N U Immune system problems?

Y N U AIDS or HIV?

Y N U Hepatitis, Jaundice, or liver problems?

Y N U Fainting spells, seizures, epilepsy or neurological problems?

Y N U Mental health disturbance or depression?

Y N U Vision, hearing, tasting or speech difficulties?

Y N U Rapid unintentional weight loss, loss of appetite?

Y N U Eating disorder, anorexia, bulimia?

Y N U High or low blood pressure?

Y N U Unusually tired or chronic fatigue?

Y N U Chest pain, shortness of breath or ankle swelling?

Y N U Cardiovascular problem (heart trouble, angina, stroke, heart defect?)

Y N U Heart murmur that requires antibiotic premedication for dental visits?

Y N U Skin disorder?

Y N U Frequent headaches, colds or sore throat?

Y N U Eye, ear, nose or throat condition?

Y N U Hayfever, asthma, sinus trouble or hives?

Y N U Tonsil or adenoid condition?

Allergies or reactions to any of the following?:

Y N U Latex (gloves, balloons)

Y N U Metals (jewelry, clothing snaps)

Y N U Acrylic or Vinyl

Y N U Foods

Y N U Animals

Y N U Other

Y N U Ibuprofen (Motrin, Advil)

Y N U Aspirin

Y N U Penicillin or other antibiotics

Y N U Sulfa drugs

Y N U Codeine or other narcotics

Y N U Local anesthetics (Novocaine)

Other History and Habits:

Y N U Tobacco smoking or chewing

Y N U Other substance abuse

Y N U Operations

Y N U Hospitalizations

Y N U Other physical problems

Describe

Family History:

Y N U Jaw size imbalance

Y N U Bleeding disorders

Y N U Diabetes

Y N U Arthritis

Y N U Severe allergies

Y N U Unusual dental problem

Females only: Y N U Is the patient getting monthly periods? For how long?

Y N U Is the patient pregnant?

PATIENT PROFILE:

Y N U Is the patient excited about the possibility of wearing braces?

Y N U Does the patient brush his/her teeth thoroughly? Floss? How often?

Y N U Does the patient need extra help with instructions?

Y N U Is the patient self-conscious about his/her teeth?

DENTAL HISTORY: Answer every question by circling Y (yes) N (no) U (unsure)

Now or in the past, has the patient had: _____ Describe: _____

Y N U Permanent or "extra" teeth removed?

Y N U Supernumerary (extra) or congenitally missing teeth?

Y N U Chipped or injured primary (baby) or permanent teeth?

Y N U Teeth sensitive to hot, cold; teeth throb or ache?

Y N U Jaw fractures, cysts or mouth infections?

Y N U "Dead teeth" or root canals?

Y N U Any periodontal (gum) problems? Bleeding, odor, bad taste?

Y N U Food impaction between teeth?

Y N U "Gum boils", frequent cancer sores or cold sores?

Y N U Thumb or finger sucking habit? Until what age?

Y N U Abnormal swallowing or tongue thrust habit?

Y N U History of speech problems?

Y N U Mouth breathing, snoring, or difficulty breathing?

Y N U Tooth grinding or jaw clenching?

Y N U Pain/difficulty chewing, jaw opening, clicking, or ringing in the ears?

Y N U Treatment for "TMJ" problems or "TMD"?

Y N U Aware of loose, broken, or missing restorations (fillings)?

Y N U Any teeth irritating cheek, lip, tongue or palate?

Y N U Concerned about spaced, protruding or crooked teeth?

Y N U Aware or concerned about under or over developed jaw?

Y N U Any relative with similar tooth or jaw relationships?

Y N U Any wisdom tooth problems?

Y N U Had any serious trouble associated with previous dental treatment?

Y N U Been under another dentist's care? Specialist?

Y N U Ever had a prior orthodontic examination or treatment?

Y N U Would patient object to wearing braces should they be indicated?

Patient's Physician _____ Phone _____

Date last seen _____ Reason _____

I have read and understand the above questions. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later of this history record or medical/dental status, I will so inform the practice.

Signed (Parent/Guardian) _____ Date _____

Dr/Staff member _____ Date _____