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# Medical Dental History Form

## Patients Under 18 Years of Age

Date:_____

**Patients Name**:_____ **Date of Birth**:_____Age:_____Sex:_____
Patients Address:_____City:_____State:_____Zip:_____
Home Phone #:_____ **Cell Phone #:_____ **Cell Phone Company**:_____
**Family Email Address:_____
**Fathers Name**:_____ Home #:_____Cell #:_____Company:_____
Address:_____ City:_____ State:_____Zip:_____
Occupation:_____Employer:_____ Work #:_____
**Social Security Number**:_____ **Date of Birth**:_____ **Email**:_____

Cell Phone
**Mothers Name**:_____Home #:_____Cell #:_____Company:_____
Address:_____ City:_____ State:_____ Zip:_____
Occupation:_____ Employer:_____ Work Phone:_____
**Social Security Number**:_____ **Date of Birth**:_____ **Email**:_____

**Parents are**: Single____ Married____ Widowed____ Separated____ Divorced____

**Names and ages of other children in family**:_____ **Family Members in Treatment**:_____
Patients School:_____Sports, Hobbies & Avocations:_____

## Dental History

**Name of Patients Dentist:**_____ Phone #:_____Referred By:_____

Last Dental Visit:_____Dental Work Being Done Now: Y___ N___If Yes, What:_____

Has the Patient had Orthodontic Treatment or Evaluation?_____If Yes, By Whom:_____
What do you feel are the Orthodontic Problems: □ Alignment of Teeth □ Dental Protrusion □ Facial Features □ Other
Please explain:_____
Who First Noticed the Need for Orthodontic Treatment?_____
Additional Comments:_____

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Y__ N__ Permanent or extra teeth removed/missing
Y__ N__ Jaw fracture, cysts, mouth infections
Y__N__ Is child taking any form of Fluoride?
Y__N__ Mouth breathing habit, snoring, difficulty breathing
Y__N__ Onset of puberty (approximate date)_____
Y__N__ Has patient had any serious trouble associated with any previous dental treatment?

Y__N__ Chipped or otherwise injured primary (baby) or permanent teeth
Y__N__ Bleeding gums, bad taste, mouth odor
Y__N__ Has patient ever had periodontal gum treatment?
Y__N__ Does patient experience any pain or soreness in the muscles of the face or around the ears ?
Y__N__ Thumb or finger sucking habit until_____

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# Medical History

**Health Quality**: □ Good □ Fair □ Poor **Allergies**: □ None □ Food □ Drug □ Hay Fever □ Asthma □ Other

**Specific Type of Food/Drug Allergy**:_____

**Has the patient had any of the following**: (**Please Circle**)

| | | | | | |
|---|---|---|---|---|---|
| Hepatitis | Diabetes | Kidney Problems | Sinus Problems | Immune Disorder | Lip or Tongue Biting |
| Frequent Headaches | Heart Disease | Bleeding Gums | Arthritic Conditions | Speech Impairment | Nail Biting |
| Cerebral Palsy | Epilepsy | Liver Disease | Convulsions/Seizures | Tonsils/Adenoids | Tuberculosis |
| Rheumatic Fever | Excessive Bleeding | Cold Sores/Fever Blisters | Throat Infections | Mouth Breathing | Hemophilia |
| Frequent Colds | Thyroid Problems | Dizziness or Fainting | Grinding of Teeth | Thumb/Finger Sucking | Difficult Breathing |
| Latex Sensitivity | Artificial Joints | AIDS/HIV | Radiation Therapy | Chemotherapy | Cancer/Tumors |
| Anemia | Vision Impairment | Hearing Impairment | Cardiovascular Problems | Mental Health/Behavioral Problems | |
| High Blood Pressure | Low Blood Pressure | Other | | | |

**Please Explain Above**:_____

**If the patient is female, has she started her menstrual cycle**: Yes____ No____ **If yes, is the patient currently pregnant**: Yes____ No ____

**Physician**:_____Phone #:_____

**List Drugs Regularly Taken & Reason**:_____
_____

## Orthodontic Insurance

**Primary**

Orthodontic Coverage: Yes____ No____
Group # (plan or policy #):_____
Insurance Co. Phone #:_____
Insured's Name:_____
****Subscriber D.O.B.: _____**

Insurance Co. Name: _____
Subscriber's I.D. #:_____
Insurance Co. Address:_____
Insured's Employer:_____
****Subscriber SSN: _____**

**Person Financially Responsible for Account**: _____
**Phone Number**:_____****Cell Phone Number**_____****Cell Phone Company** _____
**Address**:_____**City/State/Zip**:_____
****Financially Responsible Party's Email Address**_____

**Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps or problems that might be encountered during treatment?**_____
_____

I certify that I have answered the above questions to the best of my ability. I will not hold Dr. F Brent May or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form. If there are any changes to this history record or medical/dental status, I will so inform this practice.

_____ _____
**Signature of Parent or Guardian** **Date**

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