

**MEDICAL DENTAL HISTORY FORM
UNDER 18**

Date: _____ School: _____

Patient's Name: _____ Gender: _____
LAST FIRST MIDDLEAddress: _____
STREET CITY STATE ZIP

Home Phone: _____ Birth Date: _____ Social Security #: _____

If patient is minor, give parent or guardian's name: _____

Patient Email: _____ Responsible Party Email: _____

Method of appointment reminder: Email Text: (_____) - _____ /carrier: _____**RESPONSIBLE PARTY INFORMATION**Name: _____ Marital Status: _____
LAST FIRST MIDDLEResidence Address: _____
STREET CITY STATE ZIPMailing Address: _____
STREET/P.O. BOX CITY STATE ZIP

How long at this address: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ Alternate Phone: _____

Previous Address (if less than 3 years): _____
STREET CITY STATE ZIP

Social Security #: _____ Birth Date: _____ Relationship to Patient: _____

Employer: _____ No. Years Employed: _____

Occupation: _____ Occupation No. _____

Spouse's Name: _____ Relationship to Patient: _____
LAST FIRST MIDDLE

Spouse's Employer: _____ Occupation No. _____ Years Employed: _____

Spouse's Social Security #: _____ Spouse's Birth Date: _____

INSURANCE INFORMATION

Insured's Name: _____ DOB: _____ Insured's Soc. Sec. #: _____

Insurance Company: _____ Group #: _____ Local No.: _____

Insurance Co. Address: _____

Do you have dual coverage?: Yes No If Yes, please continue:

Insured's Name: _____ Birth Date: _____ Insured's Soc. Sec. #: _____

Insurance Company: _____ Group #: _____ Local No.: _____

Insurance Co. Address: _____

Insured's Employer: _____

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____

Complete Address: _____

Phone: _____ Relationship to Patient: _____

Signature: _____ Date: _____

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

Now or in the past, have you had:

- yes no dk/u Birth defects or hereditary problems?
- yes no dk/u Bone fractures, any major accidents?
- yes no dk/u Rheumatoid or arthritic conditions?
- yes no dk/u Endocrine or thyroid problems?
- yes no dk/u Kidney problems?
- yes no dk/u Diabetes? If yes, Type I or Type II?
- yes no dk/u Cancer, tumor, radiation treatment or chemotherapy?
- yes no dk/u Stomach ulcer or hyperacidity?
- yes no dk/u Polio, mononucleosis, tuberculosis or pneumonia?
- yes no dk/u Problems of the immune system?
- yes no dk/u AIDS or HIV positive?
- yes no dk/u Hepatitis, jaundice or liver problem?
- yes no dk/u Fainting spells, seizures, epilepsy or neurological problem?
- yes no dk/u Mental health disturbance or behavioral problem?
- yes no dk/u Vision, hearing, tasting or speech difficulties?
- yes no dk/u Loss of weight recently, poor appetite?
- yes no dk/u History of eating disorder (anorexia, bulimia)?
- yes no dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?
- yes no dk/u High or low blood pressure?
- yes no dk/u Tires easily?
- yes no dk/u Chest pain, shortness of breath or swelling ankles?
- yes no dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
- yes no dk/u Skin disorder?
- yes no dk/u Does the patient eat a well-balanced diet?
- yes no dk/u Frequent headaches, colds or sore throats?
- yes no dk/u Eye, ear, nose or throat condition?
- yes no dk/u Tonsil or adenoid conditions?
- yes no dk/u Hayfever, asthma, sinus trouble?

Allergies or reactions to any of the following:

- yes no dk/u Latex (gloves, balloons)
 - yes no dk/u Metals (jewelry, clothing snaps)
 - yes no dk/u Local anesthetics, such as Lidocaine
 - yes no dk/u Acrylic
 - yes no dk/u Medications (please specify) _____
 - yes no dk/u Foods (please specify) _____
 - yes no dk/u Other substances (specify) _____
 - yes no dk/u Are you taking medication, nutrient supplements, herbal medications or non-prescription medicine? If yes, please name them:
Medication _____ Taken for _____
Medication _____ Taken for _____
 - yes no dk/u Does the patient currently have or ever had a substance abuse problem?
 - yes no dk/u Does the patient smoke or chew tobacco?
 - yes no dk/u Operations? Describe: _____
 - yes no dk/u Hospitalized? For: _____
 - yes no dk/u Being treated by another health care professional?
If yes, for: _____
 - yes no dk/u Other physical problems or symptoms?
Describe: _____
- Are there any other medical conditions (including family medical conditions) that we should be aware of? _____

Who may we thank for referring you to our office:

General Dentist's Name: _____

Now or in the past, have you had:

- yes no dk/u Started teething very early or late?
- yes no dk/u Primary (baby) teeth removed that were not loose?
- yes no dk/u Permanent or "extra" (supernumerary) teeth removed?
- yes no dk/u Supernumerary (extra) or congenitally missing teeth?
- yes no dk/u Chipped or otherwise injured primary (baby) or permanent teeth?
- yes no dk/u Teeth sensitive to hot or cold; teeth throb or ache?
- yes no dk/u Jaw fractures, cysts or mouth infections?
- yes no dk/u "Dead teeth" or root canals treated?
- yes no dk/u Bleeding gums, bad taste or mouth odor?
- yes no dk/u Periodontal "gum problems"?
- yes no dk/u Food impaction between teeth?
- yes no dk/u "Gum Boils", frequent canker sores or cold sores?
- yes no dk/u Thumb, finger, or sucking habit? Until what age? _____
- yes no dk/u Abnormal swallowing habit (tongue thrusting)?
- yes no dk/u History of speech problems?
- yes no dk/u Mouth breathing habit, snoring or difficulty in breathing?
- yes no dk/u Tooth grinding, jaw clenching clicking or locking?
- yes no dk/u Any pain in jaw or ringing in the ears?
- yes no dk/u Any pain or soreness in the muscles of the face or around the ears?
- yes no dk/u Difficulty encountered in chewing or jaw opening?
- yes no dk/u Aware of loose, broken or missing restorations (fillings)?
- yes no dk/u Any teeth irritating cheek, lip, tongue or palate?
- yes no dk/u Concerned about spaced, crooked or protruding teeth?
- yes no dk/u Aware or concerned about under or over developed jaw?
- yes no dk/u Any relative with similar tooth or jaw relationships?
- yes no dk/u Any wisdom tooth problems?
- yes no dk/u Had periodontal (gum) treatment?
- yes no dk/u Had any serious trouble associated with any previous dental treatment?
- yes no dk/u Ever had a prior orthodontic examination or treatment?
- yes no dk/u Been under another dentist's care?
- yes no dk/u Been under another dental specialist's care?
- yes no dk/u Would patient object to wearing orthodontic appliances (braces) should they be indicated?

GIRLS ONLY

- yes no dk/u Has the patient started her monthly periods? If so, approximately when? _____
- yes no dk/u Are you pregnant?

PATIENT PROFILE

- yes no dk/u Does patient follow directions well?
- yes no dk/u Does patient brush his/her teeth conscientiously?
- yes no dk/u Does patient have learning disabilities or need extra help with instructions?
- yes no dk/u Is patient self-conscious about teeth?

I understand the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical history.

Signature: _____

Date: _____ Date: _____ Date: _____

Doctor: _____

Date: _____ Date: _____ Date: _____