PELUSO orthodontics

Medical Dental History Under Age 18

PATIENT

Date _____
Patient's Last name _____ First name _____Middle initial____
Birth date _____ Sex: ☐Male ☐ Female I prefer to be called _____
Hobbies_____ School _____Grade_____
Home address _____ City, State, Zip code _____

PARENT/GUARDIAN

Parent/Guardian full name_____ Relationship to Patient_____
Address (if different) _____ Occupation_____
Cell Phone (if different) _____Home Phone_____ Email_____

Parent/Guardian full name_____ Relationship to Patient_____
Address (if different) _____ Occupation_____
Cell Phone (if different) _____Home Phone_____ Email_____

DENTIST

Patient's Dentist _____ Address, City, State _____
Last seen _____ Reason _____ Next appointment _____

GENERAL INFORMATION

What concerns you about your child's teeth? _____
How does your child feel about orthodontic treatment? _____
How did you hear about our office? _____
Does your child play a musical instrument? _____
Have any other family members been treated in this office? Please name them._____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____
Address (if different) _____ City, State, Zip _____
Home phone_____ Cell Phone_____Email_____

DENTAL INSURANCE

Primary policy holder's full name _____ Birthdate _____
Social Security #___-___-_____Relationship to patient _____
Address and phone (if not listed above) _____
Employer _____ Insurance company _____
Group # _____ ID # _____

PATIENT HEALTH INFORMATION

Does the patient take any pre-medication before any dental procedures? ☐Yes ☐No
Does the patient currently have (or ever had) a substance abuse problem? _____
Do you think that any of your child's activities have affected his/her face, teeth or jaws? How? _____
Does your child chew or smoke tobacco? _____
Any other physical problems? _____
Please list any medication, supplements or non-prescription medicines, including fluoride supplements that your child takes.
_____

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, mark yes or no.

MEDICAL HISTORY

Now or in the past, has the patient had:
☐**YES** ☐**NO** Emotional, sensory or developmental issues?
☐**YES** ☐**NO** Birth defects or hereditary problems?
☐**YES** ☐**NO** Bone fractures, or major injuries?
☐**YES** ☐**NO** Any injuries to face, head, neck?
☐**YES** ☐**NO** Arthritis or joint problems?
☐**YES** ☐**NO** Cancer, tumor, radiation or chemotherapy?
☐**YES** ☐**NO** Endocrine or thyroid problems?
☐**YES** ☐**NO** Diabetes or low sugar?
☐**YES** ☐**NO** Kidney problems?
☐**YES** ☐**NO** Immune system problems?
☐**YES** ☐**NO** History of osteoporosis?
☐**YES** ☐**NO** AIDS or HIV positive?
☐**YES** ☐**NO** Hepatitis, jaundice or other liver problems?
☐**YES** ☐**NO** Polio, mononucleosis, tuberculosis, pneumonia?
☐**YES** ☐**NO** Seizures, fainting spells, neurologic problems?
☐**YES** ☐**NO** Mental health disturbance or depression?
☐**YES** ☐**NO** History of eating disorder?
☐**YES** ☐**NO** Frequent headaches or migraines?
☐**YES** ☐**NO** High or low blood pressure?
☐**YES** ☐**NO** Excessive bleeding or bruising tendency, anemia?
☐**YES** ☐**NO** Does your child eat a well-balanced diet?
☐**YES** ☐**NO** Angina arteriosclerosis, stroke or heart attack?
☐**YES** ☐**NO** Chest pain, shortness of breath, tire easily, swollen ankles?
☐**YES** ☐**NO** Vision, hearing or speech problems?
☐**YES** ☐**NO** Frequent ear infections, colds, throat infections?
☐**YES** ☐**NO** Asthma, sinus problems, hayfever?
☐**YES** ☐**NO** Tonsil or adenoids removed?
☐**YES** ☐**NO** Does your child frequently breathe through his/her mouth?

DENTAL HISTORY

Now or in the past, has the patient had:
☐**YES** ☐**NO** Erupting teeth very early or very late?
☐**YES** ☐**NO** Primary teeth removed that were not loose?
☐**YES** ☐**NO** Permanent or extra teeth removed?
☐**YES** ☐**NO** Extra or congenitally missing teeth?
☐**YES** ☐**NO** Chipped or injured primary or permanent teeth?
☐**YES** ☐**NO** Any sensitive or sore teeth?
☐**YES** ☐**NO** Jaw fractures, cysts, infections?
☐**YES** ☐**NO** Any teeth treated with root canals or pulpotomies?
☐**YES** ☐**NO** Frequent canker sores or cold sores?
☐**YES** ☐**NO** History of speed problems or speech therapy?
☐**YES** ☐**NO** Difficulty breathing through your nose?
☐**YES** ☐**NO** Mouth breathing habit or snoring at night?
☐**YES** ☐**NO** Frequent habit of thumb/finger sucking?
☐**YES** ☐**NO** Frequent habit of tongue thrust?
☐**YES** ☐**NO** Teeth causing irritation to lip, cheek or gums?
☐**YES** ☐**NO** Tooth grinding or clenching?
☐**YES** ☐**NO** Clicking, locking in jaw joins?
☐**YES** ☐**NO** Soreness in jaw muscles or face muscles?
☐**YES** ☐**NO** Has your child been treated for "TMJ" or "TMD"
☐**YES** ☐**NO** Any broken or missing fillings?
☐**YES** ☐**NO** Ever been diagnosed with gum disease?

How often do you brush? _____
How often do you floss? _____

RELEASE AND WAIVER

I have read the above questions and understand them. I will not hold my orthodontist or any member of his 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:_____
Dentist Signature:_____ Date:_____