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MEDICAL HISTORY FORM
FOR PATIENTS UNDER 18 YEARS OF AGE

Patient's Name: _____ Nickname: _____
Last *First* *Middle*

Age: Date of Birth: ( ) Male ( ) Female Height: Weight: _____

School: Grade: Onset of puberty? Yes No _____

Parent's Names: (Father) (Mother) _____

Parent is: Single( ) Married ( ) Widowed ( ) Separated ( ) Divorced( ) Remarried ( )

Address: City: State: Zip: _____

Home Phone #: Father's Work#: Mother's Work#: _____

Father's Employer: Mother's Employer: _____

Person Responsible for this account: His/Her SS#: _____

Address if different from above: _____

Dentist's Name: Phone #: Date of last visit: _____

Physician's Name: Phone #: _____

Dental Insurance Company: Subscriber's SS#: _____

What concerns about your child's teeth brought you to our office? _____

How did you hear about our office? _____

PLEASE CHECK ANY THAT APPLY:

Medical History
( ) Allergies or asthma
( ) Allergies to latex / metals
( ) Heart Murmur
Requiring pre-medication Y / N
( ) Heart problems
( ) Rheumatic fever
( ) Blood disorders
( ) Hepatitis
( ) Liver or kidney disorders
( ) Diabetes
( ) Cancer
( ) Nail or lip biting
( ) AIDS antibody positive
( ) STD's
( ) Tonsils removed
( ) Speech problems
( ) Mouth breathing
( ) Previous orthodontic care

Dental History
( ) Missing or extra teeth
( ) Clenching or grinding of teeth
( ) Problems or pain associated with muscles or joints of jaw
( ) Early loss of baby teeth
( ) Thumb or finger sucking
( ) Trauma to face or teeth
( ) Nail or lip biting
( ) Thumb or finger sucking

Does your child regularly receive any medicine and/or medical treatment?( )Yes ( ) No If yes, please specify:

_____

Has your child ever had an unfavorable reaction to any drugs, antibiotics, or anesthetics? ( ) Yes ( ) No If yes, please give details:

_____

Other significant physical or mental health considerations (past or present):

_____

Because your child is a minor, it is necessary that a signed permission be obtained from a parent or guardian before any orthodontic services can be started. I have read and understand the above questions. The information provided is accurate to the best of my knowledge. 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. It is my responsibility to notify this practice if there are any changes later to this history record or medical/dental status.

_____

Signature of parent or guardian Date

Yes, I would like to receive email appointment reminders **Email Address**_____

Thank you for your cooperation. The above information is important in your child's diagnosis and treatment, and will be kept **confidential.**

Office use: Medical/dental information above reviewed with patient. Initials _____ Date _____

Comments: _____

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