BauerHite
ORTHODONTIC SPECIALISTS
The Difference is in the Details

CONFIDENTIAL MEDICAL DENTAL HISTORY FORM FOR PATIENTS UNDER AGE 18

DATE _____

PATIENT

Name _____ ☐ M ☐ F
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP

Home Phone _____ Birthdate _____ Social Security # _____

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

Whom may we thank for referring you to our office? _____

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Name _____ Marital Status _____
LAST FIRST MIDDLE

Residence _____
STREET CITY STATE ZIP

Mailing Address _____

How long at this address _____ E-mail Address _____

Cell Phone _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs) _____

Social Security # _____ Birthdate _____ Relationship to patient _____

Employer _____ Occupation _____ Years Employed _____

Spouse's Name _____
LAST FIRST MIDDLE

Relationship to Patient _____ Cell Phone _____

Employer _____ Occupation: _____ Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

INSURANCE INFORMATION

Insured's Name _____ Insured's Soc Sec # _____

Insurance Company _____ Group # _____ Local # _____

Insured Company Address _____

Do you have dual coverage? ☐Yes ☐NO If yes: _____

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

Insurance Company _____

Insurance Company Address _____

Insured's Employer _____

GENERAL INFORMATION

What concerns you about your child's teeth?_____

What concerns your child about his/her teeth?_____

How does your child feel about orthodontic treatment?_____

Who suggested that your child might need orthodontic treatment?_____

Why did you select our office?_____

Describe any previous orthodontic treatment or consultations. _____

Does you child play a musical instrument? _____

Brother/sister name _____ age _____ had orthodontic treatment? ☐ Yes ☐ No If yes, where?_____

Brother/sister name _____ age _____ had orthodontic treatment? ☐ Yes ☐ No If yes, where?_____

Brother/sister name _____ age _____ had orthodontic treatment? ☐ Yes ☐ No If yes, where?_____

Brother/sister name _____ age _____ had orthodontic treatment? ☐ Yes ☐ No If yes, where?_____

Have any other family members been treated in this office? Please name them. _____

_____

DENTIST

Patient's Dentist _____Address, City, State_____

Last seen: _____Reason _____Next Appt. _____

Other dentists/dental specialists now being seen:

Name_____City State_____

Reason_____

EMERGENCY INFORMATION

Name of nearest relative not living with you_____

Complete Address _____

Phone _____ Cell Phone _____

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, no, or don't know/understand (dk/u).***

MEDICAL HISTORY

Now or in the past, has your child had:

- ☐Yes ☐No ☐ DK/U Birth defects or hereditary problems?
- ☐Yes ☐No ☐ DK/U Bone fractures, or major injuries?
- ☐Yes ☐No ☐ DK/U Any injuries to face, head, neck?
- ☐Yes ☐No ☐ DK/U Arthritis or joint problems?
- ☐Yes ☐No ☐ DK/U Endocrine or thyroid problems?
- ☐Yes ☐No ☐ DK/U Diabetes or low sugar?
- ☐Yes ☐No ☐ DK/U Kidney problems?
- ☐Yes ☐No ☐ DK/U Cancer, tumor, radiation treatment or chemotherapy?
- ☐Yes ☐No ☐ DK/U Stomach ulcer, hyperacidity, acid reflux?
- ☐Yes ☐No ☐ DK/U Immune system problems?
- ☐Yes ☐No ☐ DK/U History of osteoporosis?
- ☐Yes ☐No ☐ DK/U Gonorrhea, syphilis, herpes, sexually transmitted diseases?
- ☐Yes ☐No ☐ DK/U AIDS or HIV positive?
- ☐Yes ☐No ☐ DK/U Hepatitis, jaundice or other liver problem?
- ☐Yes ☐No ☐ DK/U Polio, mononucleosis, tuberculosis, pneumonia?
- ☐Yes ☐No ☐ DK/U Seizures, fainting spells, neurologic problem?
- ☐Yes ☐No ☐ DK/U Mental health disturbance or depression?
- ☐Yes ☐No ☐ DK/U Vision, hearing, or speech problems?
- ☐Yes ☐No ☐ DK/U History of eating disorder (anorexia, bulimia)?
- ☐Yes ☐No ☐ DK/U High or low blood pressure?
- ☐Yes ☐No ☐ DK/U Excessive bleeding or bruising, anemia?
- ☐Yes ☐No ☐ DK/U Chest pain, shortness of breath, tire easily, swollen ankles?
- ☐Yes ☐No ☐ DK/U Heart defects, heart murmur, rheumatic heart disease?
- ☐Yes ☐No ☐ DK/U Angina, arteriosclerosis, stroke or heart attack?
- ☐Yes ☐No ☐ DK/U Skin disorder (other than common acne)?
- ☐Yes ☐No ☐ DK/U Do you eat a well-balanced diet?
- ☐Yes ☐No ☐ DK/U Frequent headaches or migraines?
- ☐Yes ☐No ☐ DK/U Frequent ear infections, colds, throat infections?
- ☐Yes ☐No ☐ DK/U Asthma, sinus problems, hayfever?
- ☐Yes ☐No ☐ DK/U Tonsil or adenoid condition?
- ☐Yes ☐No ☐ DK/U Does your child frequently breathe through his/her mouth?
- ☐Yes ☐No ☐ DK/U Has your child ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?
- ☐Yes ☐No ☐ DK/U Has your child ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel (tidendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders?
- ☐Yes ☐No ☐ DK/U Any serious trouble associated with previous dental treatment?
- ☐Yes ☐No ☐ DK/U Has your child ever been diagnosed with gum disease or pyorrhea?

DENTAL HISTORY

Now or in the past, has your child had:

- ☐Yes ☐No ☐ DK/U Erupting teeth very early or very 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 injured primary or permanent teeth?
- ☐Yes ☐No ☐ DK/U Any sensitive or sore teeth?
- ☐Yes ☐No ☐ DK/U Any lost or broken fillings?
- ☐Yes ☐No ☐ DK/U Jaw Fractures, cysts, infections?
- ☐Yes ☐No ☐ DK/U Any teeth treated with root canals or pulpotomies?
- ☐Yes ☐No ☐ DK/U Frequent canker sores or cold sores?
- ☐Yes ☐No ☐ DK/U History of speech problems or speech therapy?
- ☐Yes ☐No ☐ DK/U Difficulty breathing through nose?
- ☐Yes ☐No ☐ DK/U Mouth breathing habit or snoring at night?
- ☐Yes ☐No ☐ DK/U History of speech problems?
- ☐Yes ☐No ☐ DK/U Frequent oral habits (sucking Finger, chewing pen, etc.)?
- ☐Yes ☐No ☐ DK/U Teeth causing irritation to lip, cheek or gums?
- ☐Yes ☐No ☐ DK/U Tooth grinding or clenching?
- ☐Yes ☐No ☐ DK/U Clicking, locking in jaw joints?
- ☐Yes ☐No ☐ DK/U Soreness in jaw muscles or face muscles?
- ☐Yes ☐No ☐ DK/U Ringing in ears, difficulty in chewing or opening jaw?
- ☐Yes ☐No ☐ DK/U Has your child ever been treated For "TMJ" or "TMD" problems?
- ☐Yes ☐No ☐ DK/U Any broken or missing Fillings?

Has your child had allergies or reactions to any of the following:

- ☐Yes ☐No ☐ DK/U Local anesthetics (novocaine, lidocaine, xylocaine)
- ☐Yes ☐No ☐ DK/U Latex (gloves, balloons)
- ☐Yes ☐No ☐ DK/U Aspirin
- ☐Yes ☐No ☐ DK/U Ibuprofen (Motrin, Advil)
- ☐Yes ☐No ☐ DK/U Penicillin
- ☐Yes ☐No ☐ DK/U Other antibiotics
- ☐Yes ☐No ☐ DK/U Metals (jewelry, clothing snaps)
- ☐Yes ☐No ☐ DK/U Acrylics
- ☐Yes ☐No ☐ DK/U Plant pollens
- ☐Yes ☐No ☐ DK/U Animals
- ☐Yes ☐No ☐ DK/U Foods
- ☐Yes ☐No ☐ DK/U Other substances _____

PATIENT HEALTH INFORMATION

Do you think that any of your child's activities affect his/her face, teeth or jaws? How? _____

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that your child takes.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Does the patient currently have (or ever had) a substance abuse problem? _____

Does your child chew or smoke tobacco? _____

Have you noticed any unusual changes in your child's face or jaws? _____

Any other physical problems? _____

FAMILY MEDICAL HISTORY

Have the parents or siblings ever had any of the following health problems? If so, please Explain.

Bleeding disorders _____

Diabetes _____

Arthritis _____

Severe allergies _____

Unusual dental problems _____

Jaw size imbalance _____

Other family medical conditions? _____

How often does your child brush? _____

How often does your child floss? _____

RELEASE AND WAIVER

I authorize release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company.

Parent/Guardian Signature _____ Date _____

I have read the above question and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any error or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my child's medical or dental health.

Signature _____ Date _____

MEDICAL HISTORY UPDATES OR CHANGES

Changes _____

Parent/Guardian Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Parent/Guardian Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Parent/Guardian Signature _____ Date _____

Dental Staff Signature _____ Date _____