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Salisbury, MD 21804

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9956 North Main St., Unit 1
Berlin, MD 21811

CONFIDENTIAL

Date:_______________

MEDICAL DENTAL HISTORY FORM

Patient's Last Name:________________ First Name:________________ Middle Name:________________

Birth Date:____/____/____ Age:____ Sex: Male ☐ Female ☐ Prefers To Be Called:________________

S.S.N:______-______-______ Email: ________________ Best way to contact you? ________________

Patient's Address:________________________________

City:________________ State:________________ Zip:________________

Sports and/or Hobbies:________________ Whom may we thank for referring you to our office?________________

Why did you select our office?________________ List any family members that have been treated here?________________

Who is Financially Responsible for this Account?________________ Employer:________________

Home Phone:________________ Work No.:________________ Cell No.:________________ SSN:________________

Address (if different from patient's):________________ City:________________ State:________ Zip:________

Spouse's Name:________________ Employer:________________ Work No.:________________ Cell No.:________________

PATIENTS UNDER 18 YEARS OF AGE

Custodial Parent(s) or Guardian (s) (if different from above):________________ Phone No.:________________

Address (if different from patient's):________________ Work Phone No.:________________

City:________________ State:________ Zip:________ Cell Phone No.:________________

Insurance coverage for Orthodontic Treatment? Yes ☐ No ☐

Primary Policy Holder's Name:________________ S.S.N:________________

Birth Date:________________ Employed By:________________

Dental Insurance Company:________________ Group No.:________________

Secondary Policy Holder's Name:________________ S.S.N:________________

Birth Date:________________ Employed By:________________

Dental Insurance Company:________________ Group No.:________________

Name of dentist/ Name of oral surgeon:________________________________

When was your last dental visit?________________________________

When was your last full mouth or panoramic series of x-rays?________________________________

Name and address of physician:________________________________

Please circle any of the following that apply to patient:

Bad Breath	Grinding teeth	Sensitivity to hot	Food collection between teeth
Bleeding Gums	Loose teeth or broken fillings	Sensitivity to sweets	Sensitivity to cold
Clicking or popping jaw	Periodontal treatment	Sensitivity when biting	Sores or growths in mouth

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 orthodontic evaluation.

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 sensitive or self-conscious about teeth?

MEDICAL HISTORY

☐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?
☐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 problems?
☐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 Hayfever, asthma, sinus trouble or hives?
☐yes ☐no ☐dk/u Tonsil or adenoid conditions?

Allergies or reactions to any of the following:

☐yes ☐no ☐dk/u Local anesthetics (Novocaine or Lidocaine)
☐yes ☐no ☐dk/u Aspirin
☐yes ☐no ☐dk/u Ibuprofen (Motrin, Advil)
☐yes ☐no ☐dk/u Penicillin or other antibiotics
☐yes ☐no ☐dk/u Sulfa drugs
☐yes ☐no ☐dk/u Codeine or other narcotics
☐yes ☐no ☐dk/u Metals (jewelry, clothing, snaps)
☐yes ☐no ☐dk/u Latex (gloves, balloons)
☐yes ☐no ☐dk/u Vinyl
☐yes ☐no ☐dk/u Acrylic
☐yes ☐no ☐dk/u Animals
☐yes ☐no ☐dk/u Foods (specify)____________________
☐yes ☐no ☐dk/u Other substances (specify)____________________
☐yes ☐no ☐dk/u Is the patient taking medication, nutrient supplements, herbal medications or non-prescription medicine? Please name them.

Medication________________ Taken for____________________
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 chew or smoke tobacco?
☐yes ☐no ☐dk/u Operations? Describe:____________________
☐yes ☐no ☐dk/u Hospitalized? For:____________________
☐yes ☐no ☐dk/u Other physical problems or symptoms? Describe:____
____
☐yes ☐no ☐dk/u Being treated by another health care professional? For:____________________

Date of most recent physical exam?____________________
Are there any other medical conditions that we should be aware of?____________________
____

FAMILY MEDICAL HISTORY

Do the patient's parents or siblings have any of the following health problems? If so, please explain.

Bleeding disorders____________________
Diabetes____________________
Arthritis____________________
Metabolic disturbances____________________
Severe allergies____________________
Unusual dental problems____________________
Jaw size imbalance____________________
Any other family medical conditions that we should know about?____________________
____

DENTAL HISTORY

Now or in the past, has the patient 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 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 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 "Gum Boils", frequent canker sores or cold sores?
- ☐yes ☐no ☐dk/u Taking any forms of fluoride?
- ☐yes ☐no ☐dk/u Any relative with similar tooth or jaw relationships?
- ☐yes ☐no ☐dk/u Had periodontal (gum) treatment?
- ☐yes ☐no ☐dk/u Would patient object to wearing orthodontic appliances (braces) should they be indicated?
- ☐yes ☐no ☐dk/u 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?
  Specialist________________________________
  Other____________________________________
- ☐yes ☐no ☐dk/u Does patient require pre-meds for dental treatment?

How often does your child brush?__________________ Floss?_______________

What is your primary concern? Why are you here?__________________________

____

____

I have read and understand the above questions. 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. If there are any changes later to this history record or medical/dental status, I will inform this practice. I have also received the notice of privacy practices and have been provided an opportunity to review it.

Signed:____ Date Signed: ______________________
(Parent or Guardian)

Signed:____ Date Signed: ______________________
(Dental Staff Member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments:____

Signed:____ Date Signed: ______________________
(Parent or Guardian)

Signed:____ Date Signed: ______________________
(Dental Staff Member)