TODAY'S DATE: _____ ***Welcome to our office!***

Mary Lynn Crews, D.M.D, P.C.

Orthodontic Patient Information

Patient (only) Information

Patient's Name_____ **Age**____ **Birthdate**_____ **Sex**____

Home Address_____ **City**_____ **Zip**_____

**** Please circle preferred contact number - it will be used for computer generated appointment reminder calls ****

Home Phone_____ **Work Phone (if applicable)**_____ **Cell Phone**_____

Patient's Employer/School_____ **Nickname/Preferred Name**_____

Patient's E-mail Address_____

Marital Status_____ **Patient living with** *(please circle)*: Both Parents Mother Father Spouse Self Other_____

Who is Responsible for Patient Financially?_____

Responsible Parties

Name	_____	_____
Relationship to Patient *(please circle)*	Father Mother Other_____	Father Mother Other_____
Address	_____	_____
City, State	_____	_____
Phone (Home)	_____	_____
(Work)	_____	_____
(Cell)	_____	_____
E-mail Address	_____	_____
Place of Employment	_____	_____
Occupation	_____	_____

Medical Contacts / Referrals

	Family Dentist	**Referred By**
Name	_____	_____
City, State	_____	_____

Family History (if adolescent)

Sibling(s) (Name & Age)_____

Has any other family member previously been a patient at this office? (Name)_____

Biological Parents: (1)_____Living? Y N (2)_____Living? Y N

Is patient adopted? Y N If so, does patient know? Y N Also, do you know any genetic history of biological parents? Y N

Family History (if adult)

Children (Name & Age)_____

Has any other family member previously been a patient at this office? (Name)_____

Are you adopted? Y N Do you know any genetic history of biological parents? Y N

American Association of Orthodontists
MEDICAL DENTAL HISTORY FORM - CHILD

Patient's Name: _____

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

Now or in the past, has the patient 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?

☐ 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, pneumonia?

☐ yes ☐ no ☐ dk/u Problems of the immune system?

☐ yes ☐ no ☐ dk/u AIDS, AIDS Rel complex or HIV positive?

☐ yes ☐ no ☐ dk/u Hepatitis, jaundice or liver problems?

☐ yes ☐ no ☐ dk/u Fainting/dizzy spells, seizures, epilepsy, convulsions or neurological problem?

☐ yes ☐ no ☐ dk/u Nervous conditions?

☐ 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 Tired easily?

☐ yes ☐ no ☐ dk/u Chest pain, shortness of breath or swelling ankles?

☐ yes ☐ no ☐ dk/u Cardiovascular problem (heart trouble, MVP, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic hear disease)?

☐ yes ☐ no ☐ dk/u Skin disorder?

☐ yes ☐ no ☐ dk/u Do you have 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) or **Nickel**

☐ yes ☐ no ☐ dk/u **Latex (gloves, balloons)**

☐ yes ☐ no ☐ dk/u Vinyl

☐ yes ☐ no ☐ dk/u Acrylic

☐ 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 require antibiotic premedication for teeth cleaning or for other dental procedures?**

☐ 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 Any serious Illness or Operations? Describe :

_____

☐ yes ☐ no ☐ dk/u Hospitalized? For: _____

☐ yes ☐ no ☐ dk/u Other physical problems or symptoms? Describe:

_____

☐ yes ☐ no ☐ dk/u Ever received medical treatment from allergist or ear, nose and throat specialist?

☐ 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?

_____

GIRLS ONLY

☐ yes ☐ no ☐ dk/u Has the patient started her monthly periods? *(for growth purposes)*
If so, approximately when? _____

☐ yes ☐ no ☐ dk/u Is the patient pregnant?

BOYS ONLY

☐ yes ☐ no ☐ dk/u Has the patient reached puberty? *(for growth purposes)*
If so, approximately when? _____

Turn (Over)

FAMILY MEDICAL HISTORY

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

Bleeding disorders _____

Diabetes _____

Metabolic disturbances _____

Arthritis _____

Severe allergies _____

Unusual dental problems _____

Jaw size imbalance _____

Any other patient or 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 Nail chewing habit?

☐ 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 or 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, neck or around the ears?

☐ yes ☐ no ☐ dk/u Difficulty encountered in chewing or jaw opening?

☐ yes ☐ no ☐ dk/u Dry mouth?

☐ yes ☐ no ☐ dk/u Sore tongue?

☐ yes ☐ no ☐ dk/u Frequent cough or chronic cough?

☐ yes ☐ no ☐ dk/u Stuffy nose?

☐ yes ☐ no ☐ dk/u Frequent sore throats?

☐ yes ☐ no ☐ dk/u Frequent swollen tonsils?

☐ yes ☐ no ☐ dk/u Aware of loose, broken or missing restorations (filings)?

☐ 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, cold sores or ulcers?

☐ 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 you object to wearing orthodontic appliances (braces) should they be indicated?

☐ yes ☐ no ☐ dk/u Had any serious trouble associated with any previous dental treatment?

☐ yes ☐ no ☐ dk/u Been under another dentist's care?
Specialist _____
Other _____

☐ yes ☐ no ☐ dk/u Ever had a prior orthodontic examination?
When? _____
By whom? _____
Are you seeking a 2nd opinion? _____

☐ yes ☐ no ☐ dk/u Ever had a prior orthodontic treatment?
When? _____
Doctor: _____
Duration of Treatment: _____

How often does your child brush? _____ Floss? _____

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

What do you expect from orthodontic treatment? _____

I have read and understand the above questions. I will not hold my orthodontist or any member of 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 so inform this practice.

Signed: _____ Date Signed: _____
(Parent or Guardian)

Signed: _____ Date Signed: _____
(Dental staff member)