My Life. My Smile. My Orthodontist.

CONFIDENTIAL

SCHUESSLER ORTHODONTICS

Medical Dental History Form for Patients Under Age 18

Date:

Patient

Patient's Last Name: _____ First Name: _____ Middle Initial _____

Prefers to be called: _____ Hobbies/Interest/Activities: _____

Birth Date: _____ Age _____ Sex Male ◯ Female ◯ SSN # _____

Home Address _____ City, State, Zip Code _____

Home Phone: ( ) - _____ Cell Phone: ( ) - _____ Work Phone: ( ) - _____

School: _____ Grade: _____ Email Address(es): _____

Parent/Guardian

Patient lives with (check all that apply) ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandparent(s) ☐ Other _____

Father's Full Name: _____ Title: ☐ Mr ☐ Dr ☐ Other

Occupation: _____ Email Address: _____

Social Security Number: _____ Date of Birth: _____

Address (if different) _____

Home phone: ( ) - _____ Cell phone: ( ) - _____ Work phone: ( ) - _____

Mother's Full Name: _____ Title: ☐ Mrs ☐ Dr ☐ Other

Occupation: _____ Email Address: _____

Social Security Number: _____ Date of Birth: _____

Address (if different) _____

Home Phone: ( ) - _____ Cell Phone: ( ) - _____ Work Phone: ( ) - _____

Financial Responsibility

Who is financially responsible for this account? _____

Address (if different than page 1) _____ City, State, Zip Code _____

Home Phone: ( ) - _____ Cell Phone: ( ) - _____ Email Address: _____

Who will be responsible for bringing the patient to orthodontic appointments? _____

Dentist

Patient's Dentist: _____ Address, City, State _____

Last Seen _____ Reason _____ Next Appointment _____

Other Dentist/Dental Specialist now being seen: Name: _____ City, State _____

Reason: _____

Physician

Patient's Physician: _____ City, State _____

Last Seen _____ Reason _____ Next Appointment _____

Other Physician/Health Care Provider: Name: _____ City, State _____

Reason: _____

Other Physician/Health Care Provider: Name: _____ City, State _____

Reason: _____

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 consultations: _____

Does your 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 treatemtn? ☐ 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: _____

Dental Insurance

Primary Policy Holder's Full Name: _____ Birth Date: _____

Social Security # _____ Relationship to Patient: _____

Address (if different than page 1) _____ City, State, Zip Code _____

Home Phone: ( ) - _____ Cell Phone: ( ) - _____ Work Phone: ( ) - _____

Employer: _____ Address: _____

Insurance Company: _____ Group #: _____ ID#: _____

Does this policy have orthodontic benefits? ◯ Yes ◯ No ◯ Don't Know - Please find out my benefit for me.

Secondary Policy Holder's Full Name: _____ Birth Date: _____

Social Security # _____ Relationship to Patient: _____

Address (if different than page 1) _____ City, State, Zip Code _____

Home Phone: ( ) - _____ Cell Phone: ( ) - _____ Work Phone: ( ) - _____

Employer: _____ Address: _____

Insurance Company: _____ Group #: _____ ID#: _____

Does this policy have orthodontic benefits? ◯ Yes ◯ No ◯ Don't Know - Please find out my benefit for me.

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, please mark yes, no, or don't know/understand (dk/u).

Medical History

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

Have you had allergies or reactions to any of the following?	Yes	No	DK/U
Local anesthetics (Novocaine, lidocaine)			
Latex (gloves, balloons)			
Aspirin			
Metals (jewelry, clothing snaps)			
Penicillin			
Other antibiotics			
Ibuprofen (Motrin, Advil)			
Acrylics			
Plant pollens			
Animals			
Foods			
Other substances			

Dental History

Now or in the past, have you had:	Yes	No	DK/U
Erupting teeth very early or very late?			
Primary (baby) teeth removed that were not loose?			
Permanent or extra (supernumerary) teeth removed?			
Supernumerary (extra) or congenitally missing teeth?			
Chipped or injured primary or permanent teeth?			
Any sensitive or sore teeth?			
Any lost or broken fillings?			
Jaw fractures, cysts, infections?			
Any teeth treated with root canals or pulpotomies?			
Frequent canker sores or cold sores?			
History of speech problems or speech therapy?			
Difficulty breathing through nose?			
Mouth breathing habit or snoring at night?			
Frequent oral habits (sucking finger, chewing lip, etc)?			
Teeth causing irritation to lip, cheek, or gums?			
Tooth grinding or clenching			
Clicking, locking in jaw joints			
Soreness in jaw muscles or face muscles?			
Has your child been treated for "TMJ" or "TMD" problems?			
Any serious trouble associated with previous dental treatments?			
Has your child ever been diagnosed with gum disease?			
Has your child ever had an orthodontic consultation before?			
Has your child ever had previous orthodontic treatment?			
If so when?			

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 your child take antibiotic pre-medication before any dental procedures? _____

Does your child have (or have you ever had) a substance abuse problem? _____

Does your child chew or smoke tobacco? _____

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

Any other physical problems? _____

How often do your child brush? _____ How often do your child floss? _____

Family Medical History

Have your 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? _____

_____

Release and Waiver

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

Signature: _____ Date: _____

I have read the above questions and understand them. 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. I will notify my orthodontist of any changes in my medical or dental health.

Signature: _____ Date: _____

Medical History Update or Changes

Changes: _____
Signature: _____ Date: _____
Dental Staff Signature: _____ Date: _____