Confidential Patient Medical and Dental History

Patient _____ Date of Birth _____

Physician's Name _____ Phone _____ Last Visit _____

Has patient ever been under the extended care of a physician or had any surgeries? ☐ Yes ☐ No

If yes, please explain: _____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

☐ Heart Conditions (murmur, etc.)	☐ HIV Positive	☐ Hepatitis
☐ Excessive Bleeding	☐ Tuberculosis	☐ Frequent Headaches
☐ Diabetes	☐ Asthma	☐ Kidney Infections
☐ Rheumatic Fever	☐ Epilepsy	☐ Cerebral Palsy
☐ Liver Problems	☐ Birth Defects	☐ Eyesight Problems
☐ Cancer	☐ Infections	☐ Speech Impairments
☐ Nervous Disorders	☐ ADHD	☐ Autism

☐ Other _____

Is the patient currently on any medications? ☐ Yes ☐ No If yes, list: _____

Is the patient allergic to any foods or medicines? ☐ Yes ☐ No If yes, list: _____

Last Dentist's Name _____ Phone _____ Last Visit _____

DENTAL AND ORTHODONTIC HISTORY

Were any x-rays taken at patient's last dental visit? ☐ Yes ☐ No _____

Has patient had any problems with dental exams or treatment in the past? ☐ Yes ☐ No _____

Has patient had any cavities in the past? ☐ Yes ☐ No _____

Does patient brush their teeth daily? ☐ Yes ☐ No _____

Does patient currently take a fluoride supplement tablet, gels, rinses, etc.? ☐ Yes ☐ No _____

Does patient floss their teeth daily? ☐ Yes ☐ No _____

Has patient ever received local anesthetic? ☐ Yes ☐ No _____

Has patient ever had sealants placed? ☐ Yes ☐ No _____

If applicable: Has patient been diagnosed with tooth decay in past two years? ☐ Yes ☐ No _____

Has patient experienced any trauma to the teeth? (falls, blows, chips, etc.) ☐ Yes ☐ No _____

If yes, please explain: _____

Please describe patient's diet (regular/favorite foods) _____

Has patient ever sucked thumbs or fingers? ☐ Yes ☐ No _____

Does patient have speech problems? ☐ Yes ☐ No _____

Has patient ever been informed of any extra or missing teeth? ☐ Yes ☐ No _____

Has patient ever had a previous orthodontic exam? ☐ Yes ☐ No _____

Have any family members ever needed orthodontics in the past? ☐ Yes ☐ No _____

Does patient have any pain in their jaw? ☐ Yes ☐ No _____

Does patient have any popping or clicking of the jaw joint? ☐ Yes ☐ No _____

Any orthodontic concern? _____

Please tell us about the patient's interests (favorite sports, hobbies, TV shows, travel, movies, etc.)

_____

Thank you for taking the time to fill this out!

I certify that the above information is complete and accurate.

Parent/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____