MERIDIAN PARK ORTHODONTICS

Medical & Dental History for Patients Under Age 18

Welcome! Please Tell Us About Your Child

Patient Last Name

Patient First Name M.I.

Prefers to be called

Hobbies & activities

□ Male □ Female

Birth date Age

School Grade

Home address

City State Zip

Home phone

Cell phone

Email address (appointment reminders will be sent to this address)

Parents/Guardians

Who is accompanying the patient today?

Relationship to patient?

Custodial parent(s) name(s)

Patient lives with (check all that apply)
□ mother □ father □ stepmother □ stepfather
□ grandparent(s) □ other

1st Parent Information

Relationship to patient (example: mom, dad)

Parent last name First

□ Mr. □ Mrs. □ Ms. □ Dr. □ Other

Occupation

Email address

Address *(if different)*

Home phone *(if different)*

Cell phone

Work phone

2nd Parent Information

Relationship to patient (example: mom, dad)

Parent last name First

□ Mr. □ Mrs. □ Ms. □ Dr. □ Other

Occupation

Email address

Address *(if different)*

Home phone *(if different)*

Cell phone

Work phone

General Information

What concerns you about your child's teeth? What would you like orthodontic treatment to accomplish?

What concerns your child about their teeth?

How does your child feel about orthodontic treatment?

Who suggested that your child might need orthodontic treatment?

Why did you select our office?

Has your child had previous orthodontic treatment? □ Yes □ No
Please describe:

Have you consulted with another orthodontist? □ Yes □ No

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 or friends been treated in this office? □ Yes □ No Please name them

 Patient Name_____

Medical History

Now, or in the past, has your child experienced any of the following:

Y N	Birth defects or hereditary problems	Y N	Bone fractures or major injuries	Y N	Any injury to face, head, neck
Y N	Arthritis or joint problems	Y N	Endocrine or thyroid problems	Y N	Diabetes or low blood sugar
Y N	Kidney problems	Y N	Cancer, tumor, radiation or chemotheraphy	Y N	Stomach ulcer or acid reflux
Y N	Immune system problems	Y N	Osteoporosis or bone disorders	Y N	AIDs or HIV positive
Y N	Hepatitis, jaundice or other liver problem	Y N	Polio, mononucleosis, tuberculosis, pneumonia	Y N	Seizures, fainting spells, neurologic problem
Y N	Mental illness or depression	Y N	Vision problems	Y N	Hearing problems
Y N	Eating disorders	Y N	High or low blood pressure	Y N	Excessive bleeding or anemia
Y N	Chest pain or shortness of breath	Y N	Heart defects, hear murmur, rheumatic heart disease	Y N	Stroke or heart attack
Y N	Skin disorder (other than acne)	Y N	Frequent headaches or migraines	Y N	Frequent ear or throat infections
Y N	Asthma or sinus problems	Y N	Tonsil or adenoid conditions	Y N	Use of cigarettes or cigars
Y N	Use of smokeless tobacco	Y N	Substance abuse	Y N	Treatment with bisphosphonate medications (Fosamax, Boniva, Actonel, didronel, Aredia, Skelid, or Zometa)
Y N	For female patients (when appropriate), pregnant?	Y N	For girls, Has menstruation started?	Y N	For boys, has voice changed?

Y N Other illness or medical condition_____

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

Y N	Latex	Y N	Local anesthetics (novocaine, lidocaine, xylocaine)	Y N	Penicillin
Y N	Other antibiotics	Y N	Metals (jewelry, clothing snaps)	Y N	Other substances or medications_____

Please list any **medications** or supplements that your child takes

	Taken for
	Taken for

Does your child take antibiotic pre-medication before dental procedures? □ Yes □ No

Dental History

Now or in the past, has your child experienced any of the following:

Y N	Permanent teeth removed or missing	Y N	Sucked thumb or fingers
Y N	Chipped or injured teeth	Y N	Sensitive or sore teeth
Y N	Bleeding gums, bad taste or mouth odor	Y N	Jaw cysts or infections
Y N	Frequent canker sores or cold sores	Y N	Speech problems or speech therapy
Y N	Difficulty breathing though nose or frequent mouth breathing	Y N	Snoring
Y N	Abnormal swallowing (tongue thrust)	Y N	Tooth grinding or clenching
Y N	Clicking or popping of the jaw joint	Y N	Difficulty opening or closing jaw
Y N	Soreness in jaw or facial muscles	Y N	Treatment for TMJ or TMD
Y N	Serious difficulty associated with dental treatment	Y N	Diagnosis or treatment for gum (periodontal) disease

 Patient Name_____

Dentist

Name City

Last seen Reason

Were X-rays taken? □ Yes □ No □ Don't know

Other dentists/dental specialists now being seen

Name City

Reason

Physician

Name City

Phone number

Last seen Reason

Other physicians/health care providers now being seen

Name City

Phone number

Reason

Dental Insurance

Policy holder's full name

Policy owner's birth date

Relationship to patient

Policy holder address and phone *(if not listed above)*

Employer

Ins. Co. Name

Member ID #

Group #

Does this policy have orthodontic benefits?
□ Yes □ No □ Don't know

Is your child covered by a secondary policy? □ Yes □ No

Financial Responsibility

Who is financially responsible for this account?

If this person was not listed previously, complete below:

Address

Home phone Cell phone

Email

Relationship to patient

Employer

Release and Waiver

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

Parent/GuardianSignature _____ Date _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his 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 child's medical or dental health.

Parent/GuardianSignature _____ Date _____