CONFIDENTIAL

Lawrence R. Siegel, D.D.S.
Molly A. Siegel, D.D.S.

Member American Association of Orthodontists

MEDICAL DENTAL HISTORY FORM
FOR PATIENTS UNDER 18 YEARS OF AGE

Date_____

Patient's Name_____ DOB _____ Age_____

Nickname_____ Sex: M____ F_____ Referred by_____

Address_____ City_____State____ Zip_____ Home Phone_____

Names and ages of sisters or brothers treated here_____

Father's Name_____ Phone: Home_____ Work/Cell_____

Address_____ SSN (ins. purposes)_____

Employer_____ Occupation_____

Mother's name_____ Phone: Home_____ Work/Cell_____

Address_____ SSN (ins. purposes)_____

Employer_____ Occupation_____

Responsible Party (Financial)_____

Address_____ City_____ State____ Zip_____Home Phone_____

Employer_____Work Phone_____SSN_____

Marital Status of Parents_____ **Patient's** dentist_____

Patient's Physician_____Parent's Dentist_____

DENTAL INSURANCE_____

In case we cannot reach you:

Person to contact_____ Relationship_____ Phone_____

For the following questions circle yes, no, or do not 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.

yes no dk/u Does patient follow directions?
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, self conscience?

MEDICAL HISTORY

yes no dk/u Birth defects or heredity 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 or been treated for a tumor?
yes no dk/u Stomach ulcer or hyperacidity?
yes no dk/u Polio, mono, tuberculosis, 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 problem?
yes no dk/u Fainting spells, seizures, epilepsy or neurologic problem?

yes no dk/u Mental health 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 Excessive bleeding, black and blue tendency, anemia or bleeding disorders?
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 or rheumatic heart)?
yes no dk/u Skin disorder?
yes no dk/u Do you have a normal and good diet?
yes no dk/u Frequent headaches, colds or sore throats?
yes no dk/u Eye, ear, nose, throat condition?
yes no dk/u Hayfever, asthma, sinus trouble, hives?
yes no dk/u Tonsil or adenoid conditions?
yes no dk/u Allergies or drug reactions?_____
yes no dk/u Are you taking medication, nutrient supplements or non-prescription medicine? Please name them.
_____
yes no dk/u Does the patient currently have or ever had a substance abuse problem?
yes no dk/u Operations? (surgical procedures)
yes no dk/u Hospitalized for _____
yes no dk/u Other physical problems or symptoms?
yes no dk/u Being treated by another health care professional?
For _____
Date of most recent physical exam?_____

DENTAL HISTORY

yes no dk/u Starting teeth 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 or congenitally missing teeth?
yes no dk/u Chipped or otherwise injured primary or permanent teeth?
yes no dk/u Teeth sensitive to hot or cold; teeth throb or ache?
yes no dk/u Jaw fractures, cysts, mouth infections?
yes no dk/u "Dead Teeth" root canals treated?
yes no dk/u Bleeding gums, bad taste, mouth odor?
yes no dk/u Periodontal "Gum Problems"?
yes no dk/u Food impaction between teeth?
yes no dk/u "Gum boils",frequent canker sores, cold sores?
yes no dk/u Is child taking any forms of fluoride?
yes no dk/u Thumb, finger, sucking habit? Until_____
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, difficulty breathing?
yes no dk/u Tooth grinding, jaw clenching, clicking, locking?
yes no dk/u Any pain in jaw or ringing in the ears?
yes no dk/u Does the patient experience 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, palate?
yes no dk/u Concerned about spaced, crooked, protruding teeth?
yes no dk/u Aware or concerned about under or over developed jaw?
yes no dk/u Any relative with similar tooth of jaw relationships?
yes no dk/u Any wisdom tooth problem?
yes no dk/u Has patient had any serious trouble associated with any previous dental treatment?
yes no dk/u Onset of puberty (approximate date)?_____
yes no dk/u Has patient ever had a prior orthodontic examination or treatment?
yes no dk/u Has patient recently been under another dentist's care?
Specialist_____
Other _____
yes no dk/u Has patient ever had periodontal (gum) treatment?
yes no dk/u Would patient object to wearing orthodontic appliances (braces) should they be indicated?

Date of most recent dental examination _____

How often does patient brush_____floss_____

What is the patient's (or parent's) primary concern? – Why are you here?

_____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment?

_____

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 so inform this practice.

_____

Signature of parent of guardian Date

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