LEGACY ORTHODONTICS

"Creating beautiful smiles with personalized care"

CONFIDENTIAL

MEDICAL/DENTAL HISTORY FORM FOR PATIENTS UNDER 18 YEARS OF AGE

Date: ___________

PATIENT INFORMATION

Patient's Name: ____ Prefers to be called:________________________
Last First Middle

Birth Date:____________ Age:_____ Sex: Male Female

Dentist:____

Phone number:_______________________________________

Physician:____

Phone number:_______________________________________

Birth Father's Height:______ft ______in

Birth Mother's Height:_______ft ________in

Number of Siblings:_____ Ages:________________________________

Other family members treated here:_______________________________________

____

Attends School At:____

Grade:_________

Favorite Sports/Hobbies:____

____

Referred by:____

DENTAL HISTORY

Date of last dental care:________________ Family history of orthodontic problems: ____

Were there any habits which have caused the teeth to move?(i.e. nail or lip biting, thumbsucking, etc.)? ______________________________

____

Has an orthodontist been consulted previously?____

What is your main concern? Why are you here? ____

____

Any injuries to face, mouth, or teeth in the past? YES NO

Does the patient have any speech problems? YES NO

Are there any missing or extra permanent teeth? YES NO

Does patient have clenching or grinding habits? YES NO

List any musical instruments played by mouth: _____________________________

____

Does patient have sore or sensitive teeth? YES NO

Has patient ever had any orthodontic treatment? YES NO

Is patient self-conscious about appearance of teeth? YES NO

Has a dentist shown patient how to clean his/her teeth? YES NO

How often does patient brush his/her teeth (per day)?___________________________

List type of toothbrush (hard, med., soft)_____________________________________

List any other aids (floss, stimulant, water spray device, rubber tip, toothpick) and how often used:____

When was the last professional dental cleaning?_______________________________

How often scheduled?____

Additional general dental information:____

____

____

Please complete the back of this form

MEDICAL HISTORY

Date of last medical care/physical: _________________

Has child been a patient in a hospital in the last 2 years? YES NO If yes, reason: ____

Patient's health is: Excellent Good Fair Poor

For the following, please circle YES or NO as pertaining to your child. Please describe any YES answers below under Remarks.

1. Allergies
   - a. Penicillin YES NO
   - b. Other Antibiotics YES NO
   - c. Local Anesthetics YES NO
   - d. Metals YES NO
   - e. Vinyl YES NO
   - f. Latex (gloves, balloons) YES NO
   - g. Acrylic YES NO
   - h. Others_______________________________________ YES NO
2. Arthritis YES NO
3. Asthma YES NO
4. Blood disease or Abnormal Bleeding Problems YES NO
   - a. Anemia YES NO
   - b. Clotting Problems YES NO
   - c. Other Blood Disorders________________________ YES NO
5. Diabetes YES NO
   - a. Immediate family history? YES NO
   - b. Urinates frequently? YES NO
   - c. Often thirsty? YES NO
6. Chest pains, ankle swelling, or shortness of breath? YES NO
7. Epilepsy YES NO
8. Fainting YES NO
9. Glandular disease (thyroid, etc.) YES NO
10. Heart disease YES NO
11. Heart murmur YES NO
12. Rheumatic fever YES NO
13. High blood pressure YES NO
14. Low blood pressure YES NO
15. Kidney disease YES NO
16. Liver disease, Hepatitis, Jaundice YES NO
17. Psychiatric treatment YES NO
18. Radiation treatment YES NO
19. Respiratory disease YES NO
20. Stomach or Duodenal ulcers YES NO
21. Tumor history YES NO
22. Venereal disease YES NO
23. A.I.D.S/HIV + YES NO
24. Other Medical Conditions ____
____
25. Emotional/Behavioral problems ____________________________________
____
26. Onset of puberty? (approximate date) _________________________________

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26. Has patient had excessive bleeding requiring treatment? YES NO
27. Is patient taking medicine, drugs or pills regularly? YES NO If yes, please list ____
28. Has patient experienced any unfavorable reaction to previous dental treatment? YES NO
29. Does patient require pre-medication, based on physician instruction/personal reference, prior to dental treatment? YES NO
    If yes, name of medication ____
30. Is there any other information we should know?____
31. Girls only:
    - a. Has the patient started her monthly period? YES NO
    - b. Is the patient pregnant? YES NO

REMARKS ____

____

I have read and understand the above questions. I will not hold my orthodontist at Legacy Orthodontics, or any member of their 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. I authorize Legacy Orthodontics to take x-rays, study models and photographs as diagnostic aids to make a thorough diagnosis of the patient's orthodontic needs.

Signed: ____ Date: __________________________
(Parent or Guardian)

Signed: ____ Date: __________________________
(Doctor)

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