BRACELiNE

Medical Dental History Form For Patients Under 18

PATIENT

DATE DD / MM / YYYY

Last Name:		First name(s):	
I prefer to be called:		Hobbies/Activities:	
Birth date:		Sex: Male O Female O	ID / Passport #:
School:		Grade:	
Home address:			
Home phone:			
Cell phone:			
Email:			

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PARENT/GUARDIAN

Custodial parent's name:			
Title: Mr. O Mrs. O Ms. O Miss. O Dr. O Other:		Patient lives with: Mother O Father O Stepmother O Stepfather O Grandparents O	
Home address: (if different from patient's)			
Home phone:		Work phone:	
Cell phone:		Email:	

Mother's full name:			
Title: Mr. Mrs. Ms. Miss. Dr. Other:		Occupation:	
Home address: (if different from patient's)			
Home phone:		Work phone:	
Cell phone:		Email:	

Father's full name:			
Title: Mr. Mrs. Ms. Miss. Dr. Other:		Occupation:	
Home address: (if different from patient's)			
Home phone:		Work phone:	
Cell phone:		Email:	

DENTIST

Dentist's Name:		Address:	
Last seen:		Reason:	
Next appointment:		Other specialists:	

PHYSICIAN

Physician's Name:		Address:	
Last seen:		Reason:	
Next appointment:			

Other Physician's Name:		Address:	
Last seen:		Reason:	
Next appointment:			

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DATE DD / MM / YYYY

FINANCIAL RESPONSIBILITY

Last Name:		First name(s):	
Home address: (if different from above)		Who will be responsible for bringing the patient to orthodontic appointments?	
Home phone:		Work phone:	
Cell phone:		Email:	

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?
Who referred you to our Practice?
Have you had any orthodontic treatment or consultation before? Please describe.
Describe any previous orthodontic treatment or consultations.
Does your child play a musical instrument?
Does your child do any contact sport/hobbies that may be dangerous to their teeth?
Have any other family members been treated in this office? Please name them.

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Your answers are for office records only, and are confidential. A thorough medial history is essential to a complete orthodontic evaluation.

For the following questions mark yes, no, or don't know/understand (dk/u).

MEDICAL HISTORY

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

Has your child had allergies or reactions to any of the following?	
yes ○ no ○ dk/u ○	Local anesthetics (novocaine, lidocaine, xylocaine)
yes ○ no ○ dk/u ○	Latex (gloves, balloons)
yes ○ no ○ dk/u ○	Aspirin
yes ○ no ○ dk/u ○	Ibuprofen (Motrin, Advil)
yes ○ no ○ dk/u ○	Penicillin
yes ○ no ○ dk/u ○	Other antibiotics
yes ○ no ○ dk/u ○	Metals (jewelry, clothing snaps)
yes ○ no ○ dk/u ○	Acrylics
yes ○ no ○ dk/u ○	Plant pollens
yes ○ no ○ dk/u ○	Animals
yes ○ no ○ dk/u ○	Foods
yes ○ no ○ dk/u ○	Other substances

Now or in the past, has the patient had:	
yes ○ no ○ dk/u ○	Permanent or extra (supernumerary) teeth removed?
yes ○ no ○ dk/u ○	Supernumerary (extra) or congenitally missing teeth?
yes ○ no ○ dk/u ○	Chipped or injured primary or permanent teeth?
yes ○ no ○ dk/u ○	Any sensitive or sore teeth?
yes ○ no ○ dk/u ○	Bleeding gums, bad taste or mouth odor?
yes ○ no ○ dk/u ○	Jaw fractures, cysts, infections?
yes ○ no ○ dk/u ○	Any teeth treated with root canals or pulpotomies?
yes ○ no ○ dk/u ○	"Gum boils," frequent canker sores or cold sores?
yes ○ no ○ dk/u ○	History of speech problems or speech therapy?
yes ○ no ○ dk/u ○	Difficulty breathing through nose?
yes ○ no ○ dk/u ○	Food impaction between the teeth?
yes ○ no ○ dk/u ○	Mouth breathing habit or snoring at night?
yes ○ no ○ dk/u ○	History of speech problems?
yes ○ no ○ dk/u ○	Frequent oral habits (sucking finger, chewing pen, etc.)?
yes ○ no ○ dk/u ○	Teeth causing irritation to lip, cheek or gums?
yes ○ no ○ dk/u ○	Abnormal swallowing (tongue thrust)?
yes ○ no ○ dk/u ○	Tooth grinding or clenching?
yes ○ no ○ dk/u ○	Clicking, locking in jaw joints?
yes ○ no ○ dk/u ○	Soreness in jaw muscles or face muscles?
yes ○ no ○ dk/u ○	Ringing in ears, difficulty in chewing or opening jaw?
yes ○ no ○ dk/u ○	Has your child ever been treated for "TMJ" or "TMD" problems?
yes ○ no ○ dk/u ○	Any broken or missing fillings?
yes ○ no ○ dk/u ○	Any serious trouble associate with previous dental treatment?
yes ○ no ○ dk/u ○	Have you ever been diagnosed with gum disease or pyorrhea?
yes ○ no ○ dk/u ○	Has your child ever been diagnosed with gum disease or pyorrhea?

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PATIENT HEALTH INFORMATION

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that your child takes.

Medication	Taken for
1.	
2.	
3.	

Do you think that any of your child's activities affect his/her face, teeth or jaws? How?	
Do you take antibiotic pre-medication before any dental procedures?	
Does the patient currently have (or ever had) a substance abuse problem?	
Is your child pregnant?	
Does your child chew or smoke tobacco?	
Have you noticed any unusual changes in your child's face or jaws?	
Any other physical problems?	

FAMILY MEDICAL HISTORY

Have the 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?	

How often does your child brush?	
Floss?	

RELEASE AND WAIVER

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

PARENT/GUARDIAN SIGNATURE

DD / MM / YYYY

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 child's medical or dental health.

PARENT/GUARDIAN SIGNATURE

DD / MM / YYYY

MEDICAL HISTORY UPDATES OR CHANGES

Changes

PATIENT'S SIGNATURE

DENTAL STAFF SIGNATURE

DD / MM / YYYY

Changes

PATIENT'S SIGNATURE

DENTAL STAFF SIGNATURE

DD / MM / YYYY

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