Medical Dental History Form for Patients Under Age 18

American Association of Orthodontists®
My Life. My Smile. My Orthodontist.®

Sullivan ORTHODONTICS

PATIENT Date _____

Patient's last name _____ First name _____

Prefers to be called _____ Hobbies, activities _____

Birth date _____ Sex: ☐Male ☐Female School _____ Grade _____

Home address _____ City, State, Zip code _____

PARENT / GUARDIAN

Custodial parent(s) name(s)_____

Patient lives with (check all that apply) : ☐Mother ☐Father ☐Stepmother ☐Stepfather ☐Grandparent(s)

Mother's full name _____

Address *(if different)* _____

Occupation_____ Email Address _____

Cell phone ( ) _____-_____ Work phone ( ) _____-_____

Father's full name_____

Address *(if different)* _____

Occupation_____ Email Address _____

Cell phone ( ) _____-_____ Work phone ( ) _____-_____

DENTIST

Patient's Dentist _____ Address_____

Month of Last Visit _____ Reason _____ Next appointment _____

PHYSICIAN

Patient's Physician_____ City, State_____

Last seen_____ Reason _____

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? _____

Describe any previous orthodontic treatment or consultations: _____

Does your child play a musical instrument? _____

Does your child have any pending dental needs with their dentist? _____

Brother/Sister name _____ age _____ had orthodontic treatment? ☐No ☐Yes, Where_____

Brother/Sister name _____ age _____ had orthodontic treatment? ☐No ☐Yes, Where_____

Brother/Sister name _____ age _____ had orthodontic treatment? ☐No ☐Yes, Where_____

RESPONSIBILITIES

Who is financially responsible for the child's account? _____

Who will be responsible for bringing the patient to orthodontic appointments? _____

DENTAL INSURANCE (if there are two policies, the older by birth date is the primary)

Primary policy holder's full name _____ Birth date_____ Social Security # _____

Address (if not listed above) _____ Employer_____

Insurance company_____ Group # _____ ID# _____

Does this policy have orthodontic benefits? ☐Yes ☐No ☐Don't Know

Secondary policy holder's full name _____ Birth date_____ Social Security # _____

Address (if not listed above) _____ Employer_____

Insurance company_____ Group # _____ ID# _____

Does this policy have orthodontic benefits? ☐Yes ☐No ☐Don't Know

DENTAL HISTORY (Has your child now or in the past had any of the following? please circle)

Erupting teeth very early or very late	YES	NO	Baby teeth removed that were not loose	YES	NO
Extra or congenitally missing teeth	YES	NO	Any sensitive or sore teeth	YES	NO
Any teeth treated with root canals	YES	NO	Frequent canker sores or cold sores	YES	NO
Mouth breathing habit or snoring at night	YES	NO	History of speech problems	YES	NO
Oral habits (sucking finger, chewing pens)	YES	NO	Tooth grinding or clenching	YES	NO
Clicking, locking in jaw joints	YES	NO	Soreness in jaw muscles or face muscles	YES	NO
Treated for "TMJ" or "TMD" problems	YES	NO			

Any serious trouble associated with previous dental treatment YES NO, if Yes please explain: _____

_____

MEDICAL HISTORY (Has your child now or in the past had any of the following? please circle)

Birth defects or hereditary problems	YES	NO	Any injuries to face, head, neck	YES	NO
Arthritis or joint problems	YES	NO	History of osteoporosis	YES	NO
Cancer, tumor, or chemotherapy	YES	NO	Endocrine or thyroid problems	YES	NO
Diabetes or low sugar	YES	NO	Immune system problems	YES	NO
Seizures, fainting, or neurologic problems	YES	NO	Taken Rx of bisphosphonates	YES	NO
Mental health disturbance or depression	YES	NO	Frequent headaches or migraines	YES	NO
Excessive bleeding or bruising, anemia	YES	NO	Heart defects, heart murmur	YES	NO
Frequent ear, colds, or throat infections	YES	NO	Asthma, sinus problems, hayfever	YES	NO
Tonsil or adenoid condition	YES	NO	Frequently breathe through mouth	YES	NO
Does your child have an Allergy to Latex?	YES	NO			

Does your child have any Allergies YES NO, If yes please list:_____

List any medication, nutritional supplements, herbal medications or non-prescription medicines your child takes:

Medication_____ Taken for _____

Medication_____ Taken for _____

Does your child take antibiotic pre-medication before any dental procedures? YES NO

Please provide any additional information you feel may be helpful in the diagnosis and treatment of your child:

_____

RELEASE AND WAIVER

Dr. Sullivan has my permission to obtain diagnostic materials he deems necessary for orthodontic evaluation. I also authorize him to provide other health care providers with information regarding my child's orthodontic care if considered appropriate. I also understand it is my responsibility to keep Sullivan Orthodontics informed of any change in my child's medical or dental health status.

Parent/Guardian Signature _____ Date _____