UTAH ORTHODONTIC CARE

Today's date: _____

MEDICAL/DENTAL HISTORY FORM FOR PATIENTS UNDER 18

PATIENT INFORMATION

Patient's Name: _____ DOB: _____ Age: ___ Sex: M F

I prefer to be called: _____ Attends School at: _____

Patient's Address: _____City:_____State:_____Zip Code: _____

SSN #:_____ Home Phone: _____ Grade: _____

Sports and/or Hobbies: _____

Other family members treated here? _____

Who suggested that your child might need braces? _____

How did you hear about our office? _____

Emergency Contact: _____ Phone #: _____

RESPONSIBLE PARTY INFORMATION

Mother/Guardian's Name: _____DOB:_____ SSN#:_____

Address (if different than patient): _____ City_____ State_____

Cell phone:_____ Cell company:_____Work:_____

Email Address: _____

Father/Guardian's Name:_____ DOB:_____ SSN#:_____

Address (if different than patient): _____ City_____ State_____

Cell phone:_____ Cell company:_____Work:_____

Email Address:_____

Name of Dentist: _____ Last Seen: _____Reason:_____

Name of Dental Office: _____ Phone #:_____

DENTAL INSURANCE INFORMATION

Primary Policy Holder's Name: _____ SSN#: _____ DOB __ _____

Insurance Company Name: _____

ID# _____ Phone #: _____

Secondary Policy Holder's Name: _____ SSN#: _____ DOB _____

Insurance Company Name: _____

ID# _____ Phone #: _____

DENTAL HISTORY Now or in the past, has the patient had:

□ yes □ no Any teeth removed for any reason?
□ yes □ no Supernumerary (extra) or congenitally missing teeth?
□ yes □ no Chipped or otherwise injured primary (baby) or permanent teeth?
□ yes □ no Jaw fractures, cysts or mouth infections?
□ yes □ no Periodontal problems, bleeding gums, bad taste or mouth odor?
□ yes □ no Thumb, finger or sucking habit? Until what age_____?
□ yes □ no Abnormal swallowing habit (tongue thrusting)?
□ yes □ no History of speech problems?
□ yes □ no Mouth breathing habit, snoring or difficulty in breathing?
□ yes □ no Tooth grinding, jaw clenching clicking or locking?
□ yes □ no Any pain in jaw or ringing in the ears?
□ yes □ no Treatment for "TMD" or "TMJ" problems?
□ yes □ no Aware of loose, broken or missing restorations (fillings)?
□ yes □ no Have adenoids or tonsils been removed?
□ yes □ no Any problems with wisdom teeth?
□ yes □ no Is patient sensitive or self-conscious about teeth?
□ yes □ no Ever had a prior orthodontic exam or treatment?

How often does the patient brush? _____
How often does the patient floss? _____
What concerns you about the patient's teeth?
_____
_____

MEDICAL HISTORY Now or in the past, has the patient had:

□ yes □ no Congenital heart defect?
□ yes □ no Abnormal bleeding?
□ yes □ no Diabetes?
□ yes □ no Cancer, tumor, radiation treatment or chemo?
□ yes □ no Heart murmur?
□ yes □ no Handicaps/Impairment?
□ yes □ no Convulsion/Epilepsy?
□ yes □ no Asthma?
□ yes □ no Hemophilia?
□ yes □ no HIV/AIDS?
□ yes □ no Vision, hearing, tasting or speech difficulties?
□ yes □ no Mental health disturbance or behavioral problems?
□ yes □ no Operations or surgeries?
Describe:
_____
_____

GIRLS ONLY
□ yes □ no Is the patient pregnant?
Are there any other medical conditions that we Should be aware of? _____
_____
_____

Check allergies or reactions to any of the following:

□ Aspirin
□ Penicillin or other antibiotics
□ Latex (gloves, balloons)
□ Vinyl, Acrylic or Animals
□ Ibuprofen (Motrin, Advil)
□ Tylenol
□ Sulfa Drugs
□ Metals (jewelry)
□ Foods (specify)

Please list any medication, nutrient supplements, Herbal medications or nonprescription medicine Being taken by the patient.

Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____

I have read and understand the above questions. I will not hold my treating doctor 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 be sure to inform this practice. Furthermore, I consent to an orthodontic examination and if necessary, orthodontic records which include photos, impressions, and x-rays.

Print Name: _____
(Parent or Guardian)

Signed: _____ Date Signed: _____