

**Confidential**

**R. Steven Powell, DMD, PC  
Orthodontist  
Medical - Dental History Form  
For Patients Under 18 years Of Age**

Date \_\_\_\_\_

Email \_\_\_\_\_

Whom may we thank for referring you to our office ? \_\_\_\_\_

Patient's Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Preferred name \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex : Male  Female  Home Phone # \_\_\_\_\_

Patient's Home Address -Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZipCode \_\_\_\_\_

Patient's Height \_\_\_\_\_ Weight \_\_\_\_\_ Musical instrument played \_\_\_\_\_

Favorite Sports, Hobbies, and Avocations \_\_\_\_\_

Patient's School \_\_\_\_\_ Grade \_\_\_\_\_

Name of Person Responsible for Account \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Father's Height \_\_\_\_\_ Mother's Height \_\_\_\_\_

Father's Name \_\_\_\_\_ DOB \_\_\_\_\_ Occupation \_\_\_\_\_

Employed by \_\_\_\_\_ Phone # \_\_\_\_\_

Business Address \_\_\_\_\_ Soc Sec No \_\_\_\_\_

Mother's Name \_\_\_\_\_ DOB \_\_\_\_\_ Occupation \_\_\_\_\_

Employed by \_\_\_\_\_ Phone # \_\_\_\_\_

Business Address \_\_\_\_\_ Soc Sec No \_\_\_\_\_

PARENT is Single  Married  Separated  Divorced  Widowed

Name of Patient's Dentist \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Patient's Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Names and ages of other children in family \_\_\_\_\_

In case we cannot reach you: Person to contact \_\_\_\_\_ Phone # \_\_\_\_\_

Do you have dental insurance that covers orthodontic treatment Yes  No  *If yes, please bring your insurance card with you.*

Primary Insurance Company \_\_\_\_\_ Policy No. \_\_\_\_\_

Subscriber FULL Name \_\_\_\_\_ DOB \_\_\_\_\_

Subscriber SSN \_\_\_\_\_ Relationship to Patient is \_\_\_\_\_ Child \_\_\_\_\_ Spouse \_\_\_\_\_ Self \_\_\_\_\_ Other \_\_\_\_\_

Employer Name \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ Policy No. \_\_\_\_\_

Subscriber FULL Name \_\_\_\_\_ DOB \_\_\_\_\_

Subscriber SSN \_\_\_\_\_ Relationship to Patient is \_\_\_\_\_ Child \_\_\_\_\_ Spouse \_\_\_\_\_ Self \_\_\_\_\_ Other \_\_\_\_\_

Employer Name \_\_\_\_\_

I hereby authorize release of any information necessary or relating to processing any insurance claim.

Signature of Patient, or Parent if Minor \_\_\_\_\_ Date \_\_\_\_\_

I hereby authorize payment directly to the provider of the insurance benefits otherwise payable to me.

Signature of Patient, or Parent if Minor \_\_\_\_\_ Date \_\_\_\_\_

For the following questions circle **yes, no, or don't know/understand (dk/u)**. The answers are for our office records only and will be considered confidential. A thorough and complete history is vital to 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 any learning disabilities or need extra help with instructions?  
yes no dk/u Is patient sensitive or self-conscious?

### Medical History

- yes no dk/u Birth defects or hereditary problems?  
yes no dk/u Bone fractures or 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 or hyperacidity?  
yes no dk/u Polio, mono, tuberculosis or 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 problems?  
yes no dk/u Fainting spell, seizures, epilepsy or neurologic problems?  
yes no dk/u Mental health or behavioral problems?  
yes no dk/u Vision, hearing, tasting or speech difficulties?  
yes no dk/u Recent loss of weight?  
yes no dk/u Excessive bleeding, black and blue tendency, anemia or bleeding disorder?  
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 or good diet?  
yes no dk/u Frequent headaches, colds or sore throats?  
yes no dk/u Eye, ear, nose or throat condition?  
yes no dk/u Hayfever, asthma, sinus trouble or hives?  
yes no dk/u Tonsil or adenoid conditions?  
yes no dk/u Are you taking any medication or non-prescription medicine? Please name them.

- yes no dk/u Are you allergic or sensitive to any medications? Please list:  
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.  
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 healthcare professional?  
For  
.  
Date of most recent physical  
.

- yes no dk/u If female, are you or might you be pregnant?

### Dental History

- yes no dk/u Started teething very early or late?  
yes no dk/u Baby teeth removed that were not loose?  
yes no dk/u Permanent or "extra" teeth removed?  
yes no dk/u Congenitally missing teeth?  
yes no dk/u Chipped or otherwise injured baby or permanent teeth?  
yes no dk/u Teeth sensitive to hot, cold; teeth throb or ache?  
yes no dk/u Jaw fractures, cysts or mouth infections?  
yes no dk/u "Dead Teeth" or root canals treated?  
yes no dk/u Bleeding gums or periodontal disease?  
yes no dk/u Frequent fever blisters, canker sores or cold sores?  
yes no dk/u Thumb or finger sucking habit? Until \_\_\_\_\_.  
yes no dk/u Abnormal swallowing habit (tongue thrust)?  
yes no dk/u History of speech problems?  
yes no dk/u Mouth breathing or difficulty in breathing?  
yes no dk/u Clicking or locking jaw?  
yes no dk/u Pain in jaw or ringing in ears?  
yes no dk/u Any pain or soreness in the muscles of the face or around the ears?  
yes no dk/u Difficulty in chewing or jaw opening?  
yes no dk/u Aware of loose or broken fillings?  
yes no dk/u Concerned about spaced, crooked or protruding teeth?  
yes no dk/u Aware or concerned about under or over developing jaw relationship?  
yes no dk/u Any relative with similar tooth or jaw relationship?  
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)?  
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changes) (Females - start of menses; Males - facial hair, voice

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 parents) 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 staff responsible for any errors or omissions that I have made in the completion of this form. If there are changes later to this history record or medical/dental status I will so inform this practice.

Signature of parent or guardian

Date

Medical History Update or Changes Date: Comments: Signature: