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This form is confidential

Medical-Dental History Form for Patients Under 18 Years of Age

Patient's Last Name_____ First name_____ M.I._____

Birth date_____ Age_____ Gender_____ I preferred to be called_____

Home street address_____

City_____State_____Zip_____

Home phone ( )_____-_____

School_____Sports/Hobbies_____Siblings/Ages_____

Who referred you to our practice?_____

Custodial Parent(s) or Guardian(s)_____

Address (if different than patient's)_____

City_____State_____Zip_____

Home phone ( )_____-_____ Cell phone ( )_____-_____

Work phone ( )_____-_____Extension_____

E-Mail address_____

Parents are: ____Married ____Divorced ____Separated ____Widowed ____Patient is adopted

Patient's general/family dentist_____

Dentist's phone ( )_____-_____ City your dentist is located_____

Patient's physician_____

Physician's phone ( )_____-_____ City your physician is located_____

Person responsible for this account_____

Address (if different than patient's)_____

City_____State_____Zip_____

Phone ( )_____-_____

Dental insurance information (primary): Policy holder's employer_____

Insurance Co._____ Group #_____

Policy holder's S.S.#_____-_____-_____ Policy holder's date of birth_____/_____/_____

Dental insurance information (secondary): Policy holder's employer_____

Insurance Co._____ Group #_____

Policy holder's S.S.#_____-_____-_____ Policy holder's date of birth_____/_____/_____

Medical History

Now or in the past, has the patient had any of the following?

Birth defects or hereditary conditions	___yes ___no	Major accidents	___yes ___no
Rheumatoid or arthritic conditions	___yes ___no	Osteoporosis	___yes ___no
Endocrine or thyroid conditions	___yes ___no	Kidney problems	___yes ___no
Cancer, tumors, radiation or chemotherapy	___yes ___no	Diabetes	___yes ___no
Polio	___yes ___no	Mononucleosis	___yes ___no
Tuberculosis	___yes ___no	Pneumonia	___yes ___no
Tonsil or adenoid condition	___yes ___no	Stomach ulcers	___yes ___no
Hepatitis, jaundice or liver conditions	___yes ___no	AIDS or HIV+	___yes ___no
Mental health problems or depression	___yes ___no	Fainting, seizures, epilepsy	___yes ___no
Vision, hearing, tasting or speech problems	___yes ___no	Recent loss of weight	___yes ___no
Eating disorders (anorexia or bulimia)	___yes ___no	Bleeding or blood disorders	___yes ___no
High___ or low___ blood pressure	___yes ___no	Chest pain	___yes ___no
Cardiovascular problems	___yes ___no	Shortness of breath	___yes ___no
Heart murmur or congenital heart defects	___yes ___no	Skin disorders	___yes ___no
Hay fever, chronic allergies, asthma	___yes ___no	Frequent headaches	___yes ___no
Substance abuse problem	___yes ___no	Chew or smoke tobacco	___yes ___no

Please describe any other medical condition that we should know about:

Does the patient have an allergy or reaction to any of the following?

___Local anesthetics (Novocaine, Lidocaine)	___Ibuprofen (Motrin, Advil)	___Aspirin
___Acetominophen (Tylenol)	___Penicillin or other antibiotics	___Sulfa drugs
___Codeine or other narcotics	___Metals	___Latex
___Vinyl	___Acrylic	___Foods_____

Does the patient require antibiotic medication prior to your dental cleaning appointments? ___yes ___no

Please list any medications that the patient is currently taking: **Taken for:**

Family Medical History

Do the patient's parents or siblings have or ever had any of the following conditions?

Diabetes_____ Arthritis_____ Bleeding disorders_____

Extra or undeveloped teeth_____ Long lower jaw or an "underbite"_____

Patient's current height _____ft. _____in. Birth father's height _____ft. _____in. Birth mother's height _____ft. _____in.

For Girls

Has the patient started her monthly periods? ___yes ___no Is the patient pregnant? ___yes ___no

Does the patient take birth control pills? ___yes ___no

Dental History

Does the patient have or ever had any of the following?

Extra or congenitally missing teeth	___yes ___no	Permanent or extra teeth removed	___yes ___no
Teeth sensitive to hot or cold	___yes ___no	Jaw fracture or jaw cyst	___yes ___no
Periodontal "gum" problems	___yes ___no	Thumbsucking habits	___yes ___no
Speech problems	___yes ___no	Mouth breathing or snoring	___yes ___no
Teeth grinding or clenching	___yes ___no	Pain or locking of the jaw	___yes ___no
Pain or soreness of the jaw muscles	___yes ___no	Difficult jaw opening	___yes ___no
Frequent cheek or lip biting	___yes ___no	Frequent cold or canker sores	___yes ___no

Has the patient ever had an injury to a tooth or a broken tooth? ___yes ___no

Explain_____

Has the patient ever had any of the following dental treatment?

Wisdom tooth removal	___yes ___no	Periodontal "gum" treatment	___yes ___no
TMJ jaw joint treatment	___yes ___no	Orthodontic treatment	___yes ___no

Are you aware of any dental procedures that are planned by the patient's general dentist (ex. cavities, fillings, extractions)?

List any other dental specialist who is providing care for the patient_____

Why is the patient here for an orthodontic examination?_____

Do you or the patient feel that his or her front teeth are:

___Too small or short ___Too large or long ___Crooked or crowded ___Not centered

___Misshaped, uneven or worn ___Spaced apart ___Protruded ("sticking out") ___Biting in an "underbite"

Do you or the patient feel that he or she shows too much gum tissue when smiling? ___yes ___no

Do you or the patient feel that his or her:

___Chin is too far back ___Chin is too far out ___Lips protrude too far out ___Lips are difficult to close together

If <u>permanent</u> teeth need to be extracted for orthodontic treatment, would this be acceptable to you?

___Yes, I am okay with it ___Probably, if that were the only way to get a good result ___No, absolutely not

If the patient needs to wear orthodontic braces, would he or she accept that they were visible?

___Yes, I am okay with it ___Probably, if that were the only way to get a good result ___No, absolutely not

I have read and understand the above questions. I will not hold Dr. Miyawaki 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 any changes later to this history record or medical/dental status, I will so inform this practice.

Parent's or Guardian's

signature____Date______________________