ORTHODONTICS smile
Cercone · Wear · Eliason

CONFIDENTIAL Medical – Dental History Form

(Office Use) Pt. ID:_____

Patient Information:

Date _____

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Male _____ Female _____

Medical History:

Physician's name _____ Physician's phone _____ Date last seen _____

Patient is in good health? ☐ Yes ☐ No If no, why?_____

Do you think that any of your / your child's activities affect your / his / her teeth or jaws? How?_____

Yes	No	For the following questions, please mark yes or no:
		Birth defects or hereditary problems?
		Bone fractures or major injuries?
		Any injuries to face, head or neck?
		Arthritis or joint problems?
		Cancer, tumor, radiation treatment or chemotherapy?
		Endocrine or thyroid problems?
		Diabetes or low sugar?
		Kidney problems?
		History of osteoporosis?
		Gonorrhea, syphilis, herpes, sexually transmitted diseases?
		AIDS or HIV positive?
		Hepatitis, jaundice, or other liver problems?
		Polio, mononucleosis, tuberculosis, pneumonia?
		Seizures, fainting spells, neurologic problems?
		Mental health disturbance or depression?
		History of eating disorder (anorexia, bulimia)?
		Frequent headaches or migraines?
		High or low blood pressure?
		Excessive bleeding or bruising, anemia?
		Chest pain, shortness of breath, tire easily, swollen ankles?
		Heart defects, heart murmur, rheumatic heart disease?
		Angina, arteriosclerosis, stroke or heart attack?
		Skin disorder (other than common acne)?
		Do you / or does your child eat a well balanced diet?
		Vision, hearing or speech problems?
		Frequent ear infections, colds, throat infections?
		Asthma, sinus problems, hayfever?
		Tonsil or adenoid condition?
		Frequently breathe from mouth?
		Have you / or has your child ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?
		Have you / or has your child ever taken oral bisphonates such as Fosamax (alendronate), Actone (ridendronate), Boniva (ibandrobate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders?
		Any other physical problems? Explain:

Have you / or has your child had allergies or reactions to any of the following?

Yes	No	Please mark yes or no:	Yes	No	
		Local anesthetics (novacaine, lidocaine, xylocaine)			Other antibiotics List:
		Latex (gloves, balloons)			Metals (jewelry, clothing snaps)
		Aspirin			Acrylics
		Ibuprofen (Motrin, Advil)			Plant pollens
		Penicillin			Animals
		Foods List:			Other substance List:

Medications: Please list any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you take / or your child takes.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Dental History:

Dentist's name _____ Dentist's phone _____ Date last seen _____

Other dentists/dental specialists now being seen: Name _____ City _____

Reason _____

Have you / or has your child had any injuries to the mouth/jaw area? _____ Yes_____ No

Explain: _____

Is this your first orthodontic visit? ____Yes ____No Has your dentist mentioned an orthodontic problem? ____Yes ____No

Explain: _____ Any pain or clicking when opening mouth? _____Yes _____No

Release and Waiver:

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

Patient/Guardian Signature_____**Date** _____

I have read the above questions and understand them. I will not hold my orthodontist or his/her staff responsible for any errors or omissions that I have made in completion of this form. I will notify my orthodontist of changes in my / my child's medical or dental health.

Patient/Guardian Signature_____**Date** _____

Medical History Updates or Changes:

Changes _____

Patient/Guardian Signature _____ Date _____

Dental Staff Signature_____ Date _____

Changes _____

Patient/Guardian Signature _____ Date _____

Dental Staff Signature_____ Date _____

Changes _____

Patient/Guardian Signature _____ Date _____

Dental Staff Signature_____ Date _____

Changes _____

Patient/Guardian Signature _____ Date _____

Dental Staff Signature_____ Date _____