



HERSHEY & HEYMAN
 ORTHODONTICS
Simply Spectacular Smiles

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Medical Dental History Form

CONFIDENTIAL

PATIENT

Date _____

Patient's last name _____ First name _____ Middle initial _____

Prefers to be called _____ Birth date _____ Sex: Male Female

Home address _____ City, State, Zip code _____

School _____ Hobbies, activities _____

Custodial parent(s) name(s) _____

Patient lives with (*check all that apply*) mother father stepmother stepfather grandparents(s) other _____

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

Best contact number _____ Email address _____

RESPONSIBLE PARTY

Full name _____ Relationship to patient _____

Address (*if different from above*) _____ How long at this address _____

Previous address (*if less than 3 years*) _____

Home Phone _____ Cell phone _____ Work phone _____

Social Security Number _____ Birthdate _____ Email address _____

Employer _____ Occupation _____ # of years employed _____

Spouse's full name _____ Relationship to patient _____

Cell phone _____ Work phone _____

Social Security Number _____ Birthdate _____ Email address _____

Employer _____ Occupation _____ # of years employed _____

DENTIST

Patient's Dentist _____ Date of last cleaning and check-up _____

Other dentists/dental specialists being seen: Name _____ Reason _____

GENERAL INFORMATION

What concerns you or your child about their teeth? _____

How does your child feel about orthodontic treatment? _____

Who suggested that your child may need orthodontic treatment? _____

Why did you select our office? _____

Describe any previous orthodontic treatment or consultations? _____

Do you think that any of your child's activities affect his/her face, teeth, or jaws? Yes No If yes, how? _____

Brother/sister name _____ age _____ had orthodontic treatment? Yes No If yes, where? _____

Brother/sister name _____ age _____ had orthodontic treatment? Yes No If yes, where? _____

Brother/sister name _____ age _____ had orthodontic treatment? Yes No If yes, where? _____

Have any other family members been treated in this office? Please name them _____

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation. For the following questions, please mark yes, no, or don't know/understand (DK/U)

MEDICAL HISTORY

Now or in the past, has your child had:

Yes No DK/U

- Birth defects or hereditary problems?
- Bone fractures or major injuries?
- Any injuries to face, head, neck?
- Arthritis or joint problems?
- Cancer, tumor, radiation treatment or chemotherapy?
- Endocrine or thyroid problems?
- Diabetes or low sugar?
- Kidney problems?
- Immune system problems?
- History of osteoporosis?
- 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)?
- Vision or hearing problems?
- Frequent ear infections, colds, throat infections?
- Asthma, sinus problems, hayfever?
- Tonsil or adenoid condition?
- Does your child frequently breathe through his/her mouth?
- Does your child eat a well balanced diet?

GROWTH INFORMATION

Father's Height _____ Mother's Height _____

Patient Resembles: Neither parent Mother Father
 Adopted? Yes No

Girls: Has she started menstruation? Yes No

Boys: Has his voice changed? Yes No

Has your child had allergies or reactions to any or the following?

Yes No DK/U

- Local anesthetics (novocaine, lidocaine, xylocaine)
- Latex (gloves, balloons)
- Ibuprofen (Motrin, Advil)
- Metals (jewelry, clothing snaps)
- Penicillin
- Other antibiotics
- Acrylics
- Other substances _____

DENTAL HISTORY

Now or in the past, has your child had:

Yes No DK/U

- Erupting teeth very early or very late?
- Primary (baby) teeth removed that were not loose?
- Permanent or extra (supernumerary) teeth removed?
- Supernumerary (extra) or congenitally missing teeth?
- Chipped or injured primary or permanent teeth?
- Any sensitive or sore teeth?
- Any broken or missing fillings?
- Jaw fractures, cysts, infections?
- Any teeth treated with root canals or pulpotomies?
- Frequent canker sores or cold sores?
- History of speech problems or speech therapy?
- Difficulty breathing through nose?
- Mouth breathing habit or snoring at night?
- Frequent oral habits (sucking finger, chewing pen, etc)?
- Teeth causing irritation to lip, cheek, or gums?
- Tooth grinding or clenching?
- Clicking, locking in jaw joints?
- Soreness in jaw muscles or face muscles?
- Has your child been treated for "TMJ" or "TMD" problems?
- Any serious trouble associated with previous dental treatment?
- Has your child ever been diagnosed with gum disease?

PATIENT HEALTH INFORMATION

List any medication your child takes.

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

Does your child have (or ever had) a substance abuse problem? _____

Does your child chew or smoke tobacco? _____

Have you noticed any unusual changes in your child's face or jaws? _____

Any other physical problems? _____

PHYSICIAN

Patient's Physician _____ City, State _____

Other physicians/health care providers being seen now:

Name _____ City, State _____

Reason _____

DENTAL INSURANCE

Primary policy holder's full name _____ Birth date _____

Social security # _____ Relationship to patient _____

Address and phone (if not listed on page 1) _____

Insurance company _____ Group # _____ ID# _____

Insurance company address _____

Employer _____ Does this policy have orthodontic benefits? Yes No Don't know

Secondary policy holder's full name _____ Birth date _____

Social security # _____ Relationship to patient _____

Address and phone (if not listed on page 1) _____

Insurance company _____ Group # _____ ID# _____

Insurance company address _____

Employer _____ Does this policy have orthodontic benefits? Yes No Don't know

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

Parent/Guardian Signature _____ Date _____

I understand that where appropriate, credit bureau reports may be obtained.

Parent/Guardian Signature _____ Date _____