BRAND ORTHODONTICS

ADAM J. BRAND ▪ DDS ▪ MS ▪ APC

MEDICAL/DENTAL HISTORY FORM – UNDER 18 YEARS OF AGE

Date _____/_____/_____

PATIENT INFORMATION

Patient's Name _____ Preferred Name _____
Last First Middle

Birth Date _____/_____/_____ Age _____ Gender: Male Female

Address _____

City_____ Zip_____

Home Phone #_____

School/Grade _____

Ages of other children in family_____

Referred by_____

Family e-mail _____

Dentist_____

Address_____

Phone #_____

Physician_____

Address_____

Phone # _____

RESPONSIBLE PARTY INFORMATION

Mother's Name_____

SS #_____ Birth date _____/_____/_____ Phone #_____

Employer_____

Employer Address_____

City_____ Zip_____ Work Ph #_____

Father's Name_____

SS #_____ Birth date _____/_____/_____ Phone #_____

Employer_____

Employer Address_____

City_____ Zip_____ Work Ph #_____

Do you or your spouse have dental insurance covering orthodontics? YES NO

DENTAL HISTORY

What is your main concern, and what would you most like orthodontic treatment to accomplish? _____

Is there a family history of orthodontic problems? _____

Were there any habits which have caused the teeth to move? (i.e.: finger nail or lip biting, thumb sucking, etc.)? _____

Has an orthodontist been consulted previously? _____

Has the patient had any injuries to face, mouth, or teeth in the past? YES NO

Does the patient have any speech problems? YES NO

Are there any missing or extra permanent teeth? YES NO

Does the patient have clenching or grinding habits? YES NO

Does the patient have sore or sensitive teeth? YES NO

Has the patient ever had any orthodontic treatment in the past? YES NO

Is the patient self-conscious about the appearance of his/her teeth? YES NO

How often does the patient brush his/her teeth (per day)? _____

When was the patient's last professional dental cleaning? _____

How often are the cleanings scheduled? _____

Additional general dental information:_____

_____

Please complete the back of this form.

MEDICAL HISTORY

Date of last medical care/physical: _____

Has this child been a patient in a hospital in the last 2 years? YES NO If 'yes', reason: _____

Patient's health is: Excellent Good Fair Poor

For the following, please circle YES or NO as pertaining to your child. Please describe any YES answers below under Remarks.

1. Allergies
   - a. Penicillin YES NO
   - b. Other Antibiotics YES NO
   - c. Local Anesthetics YES NO
   - d. Metals YES NO
   - e. Vinyl YES NO
   - f. Latex (gloves, balloons) YES NO
   - g. Acrylic YES NO
   - h. Others_____ YES NO
2. Arthritis YES NO
3. Asthma YES NO
4. Blood disease or Abnormal Bleeding Problems YES NO
   - a. Anemia YES NO
   - b. Clotting Problems YES NO
   - c. Other Blood Disorders_____ YES NO
5. Diabetes YES NO
   - a. Frequent urination YES NO
   - b. Often thirsty YES NO
6. Chest pains, ankle swelling, or shortness of breath YES NO
8. Fainting YES NO
9. Glandular disease (thyroid, etc.) YES NO
10. Heart disease YES NO
11. Heart murmur YES NO
12. Rheumatic fever YES NO
13. High blood pressure YES NO
14. Low blood pressure YES NO
15. Kidney disease YES NO
16. Liver disease, Hepatitis, Jaundice YES NO
17. Psychiatric treatment YES NO
18. Radiation treatment YES NO
19. Respiratory disease YES NO
20. Stomach or Duodenal ulcers YES NO
21. Tumor history YES NO
22. Venereal disease YES NO
23. A.I.D.S/HIV + YES NO
24. Other Medical Conditions _____
    _____
25. Emotional/Behavioral problems _____
    _____
26. Onset of puberty? (approximate date) _____

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27. Has patient had excessive bleeding requiring treatment? YES NO
28. Is patient taking medicine, drugs or pills regularly? YES NO If 'yes', please list _____
29. Has patient experienced any unfavorable reaction to previous dental treatment? YES NO
30. Does patient require pre-medication, based on physician instruction/personal reference, prior to dental treatment? YES NO
    If 'yes', name of medication _____
31. Is there any other information we should know? _____
32. Girls only:
    - a. Has the patient started her monthly period? YES NO
    - b. Is the patient pregnant? YES NO

REMARKS _____

_____

_____

I have read and understand the above questions. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: _____ Date: _____
(Parent or Guardian)

Signed: _____ Date: _____
(Doctor)

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