

ORTHODONTISTS OF LAKEWOOD RANCH & SARASOTA
Medical and Dental History for Patients Under 18 Years of Age

Patient's Last Name: _____ First name: _____ Middle initial: _____ Prefers to be called: _____
Date of birth: _____ Age: _____ Gender: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone #: (home) _____ Cell: _____
School: _____ Grade: _____
Sports/hobbies/interests: _____
Brothers/sisters: _____ Any family members treated here? _____

Mother's name (or guardian): _____ Job title and employer: _____
Father's name: _____ Job title and employer: _____
Additional Phone #'s: _____

Who is financially responsible for this patient's account? Last name _____ First _____ Title _____
Address (if different) _____
City _____ State _____ Zip _____ Phone # _____
Employer: _____ Job title: _____

Insurance information: Primary policy holder's: Last name _____ First _____ MI _____
Address (if different than patient) _____
City _____ State _____ Zip _____ Phone # _____
SS# _____ Date of birth _____ Employed by _____
Dental insurance company _____ Group # _____
Secondary policy holder's: Last name _____ First _____ MI _____
Address: _____
City _____ State _____ Zip _____ Phone # _____
SS# _____ Date of birth _____ Employed by _____
Dental insurance company _____ Group # _____

How did you hear about our office? _____
General dentist's name _____ City _____ State _____
Date of patients last cleaning _____ Frequency of Cleanings? 3 months 4 months 6 months
Physician's name _____ City _____ State _____

For the following questions, please mark yes (Y) or no (N). These answers are for office records only and are confidential. A thorough medical history is necessary for a proper orthodontic evaluation.

- MEDICAL HISTORY** Now or in the past has the patient had:
- Y N Learning disabilities or need extra help with instructions?
 - Y N ADD or ADHD?
 - Y N Birth defects or hereditary problems?
 - Y N Was the patient adopted?
 - Y N Rheumatoid or arthritic conditions?
 - Y N Endocrine or thyroid problems?
 - Y N Diabetes?
 - Y N Cancer, tumor, radiation treatment, or chemotherapy?
 - Y N Acid reflux?
 - Y N Tuberculosis, polio, mononucleosis, or pneumonia?
 - Y N Problems of the immune system?
 - Y N HIV or AIDS?
 - Y N Hepatitis, jaundice, or liver problem?
 - Y N Seizures, epilepsy, fainting spells, or neurological problems?
 - Y N Mental health disturbance or depression?
 - Y N Vision, hearing, taste, or speech difficulties?
 - Y N History of eating disorder, anorexia or bulimia?
 - Y N Excessive bleeding or bruising tendency, anemia, or bleeding disorder?
 - Y N High or low blood pressure?
 - Y N Cardiovascular problems such as shortness of breath, angina, heart attack?
 - Y N Heart murmur, rheumatic fever, inborn heart defects, artificial heart valves?
 - Y N Allergies or asthma?
 - Y N Ear, nose, throat, tonsil or adenoid conditions?

(continued on other side)

Allergies or reactions to any of the following:

Y N Aspirin or Ibuprofen?

Y N Penicillin or other antibiotics?

Y N Codeine or other narcotics?

Y N Metals?

Y N Latex?

Y N Other substances: _____

Please list any medications, nutrient supplements, herbal medications, or non-prescription medicine the patient is currently taking: _____

Y N Does the patient currently have or ever had a substance abuse problem?

Y N Does the patient chew or smoke tobacco?

Y N Please list any operations or hospitalizations: _____

Y N Being treated by another health care professional? For _____

For Girls Only:

Y N Has menstruation begun? When? _____

Y N Is the patient pregnant?

DENTAL HISTORY Now or in the past, has the patient had:

Y N Extra or supernumerary teeth?

Y N Congenitally missing teeth or any permanent teeth removed?

Y N Early loss of baby teeth due to decay or trauma?

Y N Trauma or injury to baby or permanent teeth?

Y N Jaw fractures, cysts, or mouth infections?

Y N Periodontal or gum problems?

Y N Thumb or finger sucking habit? Until what age? _____

Y N Tongue thrusting?

Y N History of speech problems?

Y N Mouth breathing habit?

Y N Tooth grinding, jaw clenching, clicking or locking, or other problems of the TMJ?

Y N Any pain in jaw or face, ringing in the ears, or severe headaches?

Y N Frequent canker sores or cold sores?

Y N Any relative with similar tooth or jaw relationships?

Y N Any relative with jaw size imbalance?

Y N Ever had a prior orthodontic examination or treatment?

Y N Is there anything that you would like to discuss with the doctor in private?

I have read and understand the above questions. I will not hold Orthodontists of Lakewood Ranch & Sarasota 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.

Signed: _____ **Date:** _____
(Parent/guardian)

Signed: _____ **Date:** _____
(Dental staff member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

Signed: _____ **Date:** _____
(Parent/guardian)

Signed: _____ **Date:** _____
(Dental staff member)