GROSS ORTHODONTICS

CHILD MEDICAL AND DENTAL HISTORY

PATIENT INFORMATION:

PATIENT: _____ TODAY'S DATE: ____ / _____ / _____
First MI Last

STREET ADDRESS: _____ AGE: _____

CITY: _____ STATE: _____ ZIP: _____ DOB: ____ / _____ / _____

SCHOOL: _____ MALE: ☐ FEMALE: ☐

SIBLING NAMES / AGES: _____

PARENT/GUARDIAN INFORMATION:

MOTHER: _____ MARITAL STATUS: _____
First MI Last

PREFERRED PHONE #: (_____) _____ - _____ (Home / Work / Cell) EMAIL: _____

IF ADDRESS SAME AS ABOVE, PLEASE CHECK THIS BOX: ☐ EMPLOYER: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

FATHER: _____ MARITAL STATUS: _____
First MI Last

PREFERRED PHONE #: (_____) _____ - _____ (Home / Work / Cell) EMAIL: _____

IF ADDRESS SAME AS ABOVE, PLEASE CHECK THIS BOX: ☐ EMPLOYER: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

IF APPLICABLE:
PLEASE LIST ANY OTHER LEGAL GUARDIANS OF PATIENT (step-parent, grandparent, etc.): _____

FINANCIAL AND INSURANCE INFORMATION: (*please fill out completely*)

PRIMARY DENTAL INSURANCE	
SUBSCRIBER NAME	
SUBSCRIBER SSN	_____ - _____ - _____
SUBSCRIBER DOB	_____ / _____ / _____
INSURANCE NAME	
INSURANCE PHONE #	
SUBSCRIBER MEMBER ID	
GROUP PLAN #	
ORTHO COVERAGE?	YES / NO / UNSURE

SECONDARY DENTAL INSURANCE	
SUBSCRIBER NAME	
SUBSCRIBER SSN	_____ - _____ - _____
SUBSCRIBER DOB	_____ / _____ / _____
INSURANCE NAME	
INSURANCE PHONE #	
SUBSCRIBER MEMBER ID	
GROUP PLAN #	
ORTHO COVERAGE?	YES / NO / UNSURE

RELEASE: I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance.

Parent/Guardian Signature: _____ DATE: ____ / _____ / _____

DENTAL HISTORY:

DENTIST NAME: _____ LOCATION: _____ LAST VISIT: _____ / _____
City State MONTH YEAR

HAS THE PATIENT EXPERIENCED ANY OF THE FOLLOWING:

Clenching/Grinding of teeth?	Y	N	Snoring or sleep apnea?	Y	N
Thumb/Finger sucking habit?	Y	N	Injury to face, mouth, teeth, or chin?	Y	N
Tongue thrust habit?	Y	N	Speech problems?	Y	N
Tongue tie?	Y	N	Jaw joint problems or soreness in TMJ?	Y	N
Lip or cheek biting habit?	Y	N	Chipped teeth?	Y	N
Mouth breathing or trouble breathing through nose?	Y	N	Late erupting or missing adult teeth?	Y	N
Unfavorable reaction or traumatic dental visit?	Y	N	Gum disease?	Y	N
Unusual change to face or bite?	Y	N	Previous orthodontic treatment?	Y	N

IF "YES" TO ABOVE QUESTIONS, PLEASE ELABORATE: _____

WHY ARE YOU SEEKING ORTHODONTIC TREATMENT (MAIN CONCERN)? _____

INTERESTED IN (please circle): METAL BRACES CLEAR BRACES ALIGNERS/INVISALIGN EARLY TRAETMENT/EXPANDER OTHER

HOW DID YOU HEAR ABOUT US? _____

MEDICAL HISTORY:

PHYSICIAN NAME: _____ LOCATION: _____

IS THE PATIENT CURRENTLY TAKING ANY MEDICATIONS? YES / NO

IF YES, PLEASE LIST **MEDICATION AND CONDITION**: _____

_____

PLEASE LIST ANY **ALLERGIES** (MEDICATION/FOOD/ETC.): _____

DOES THE PATIENT PRE-MEDICATE WITH ANTIBIOTICS FOR DENTAL PROCEDURES? YES / NO

HAS THE PATIENT EXPERIENCED ANY OF THE FOLLOWING:

Allergy to latex?	Y	N	Respiratory problems, asthma, tuberculosis?	Y	N
Allergy to metal?	Y	N	Cardiovascular, blood pressure, or heart problems?	Y	N
Allergy to local anesthetics (lidocaine, novocaine, etc.)?	Y	N	Gastrointestinal/liver problems or hepatitis?	Y	N
Cancer, tumor, radiation, or chemotherapy?	Y	N	Kidney problems?	Y	N
Skin problems?	Y	N	Musculoskeletal problems, arthritis, injuries?	Y	N
Neurological problems, migraines, seizures, epilepsy?	Y	N	Immunologic problems, influenza, HIV/AIDS?	Y	N
Eyes / Ears / Nose / Throat problems?	Y	N	Herpes, syphilis, gonorrhea, other STDs?	Y	N
Tonsils/adenoids removed?	Y	N	Cleft lip/palate?	Y	N
Genetic or hereditary problems?	Y	N	Eating disorders, anorexia, bulimia?	Y	N
Endocrine problems, diabetes, thyroid problems?	Y	N	Mental health problems or depression?	Y	N

IF "YES" TO ABOVE QUESTIONS, PLEASE ELABORATE: _____

DOES THE PATIENT HAVE ANY MEDICAL PROBLEM(S) NOT LISTED ABOVE? _____

SIGNATURE:

I have read the above questions and understand them. I will not hold my orthodontist or any member of 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 to the patient's medical or dental health as they come.

Parent/Guardian Signature: _____ DATE: ____ / _____ / _____