HOLMAN
ORTHODONTICS
Bracing for the Future.

Date: ________________

MEDICAL/DENTAL HISTORY FORM FOR PATIENTS UNDER 18

PATIENT INFORMATION

Patient's Name: ______________________________ I Prefer to be Called: ____________________ DOB: ___/___/___ Age: _____ Sex: M/F

Patient's Address: _____________________________________ City: ___________________ State: ___________ Zip Code: ____________

Home Phone No.: ______________________ Attends School At: ____ Grade: ________

Sports And/Or Hobbies: _____________________________________ Other family members treated here: _____________________________

Who suggested that your child might need orthodontic treatment? ____

How did you first learn about our office: ____

RESPONSIBLE PARTY INFORMATION

Mother/Guardian's Name: _____________________________________ DOB: ____________ SS #: _____________________

Address (if different than patient's): __________________________________ City: ________________ State: _______ Zip Code: _________

Phone No (if different than patient's): ____________________ Work No: _____________________ Cell No: ___________________

Father/Guardian's Name: _____________________________________ DOB: ____________ SS #: _____________________

Address (if different than patient's): __________________________________ City: ________________ State: _______ Zip Code: __________

Phone No (if different than patient's): ___________________ Work No: _____________________ Cell No: ____________________

E-mail address: ____

Name of Patient's Dentist: ________________________________ Date Last Seen: _________________ Reason: ___________________

Name of Patient's Physician: ______________________________ Date Last Seen: _________________ Reason: ___________________

DENTAL INSURANCE INFORMATION

Primary Policy Holder's Name: ______________________________ SS#: _________________ ID#: ___________________DOB: ___/___/___

Insurance Company: _______________________________ Phone No: ____________________

Insurance Company Address: ____

Secondary Policy Holder's Name: ____________________________ SS#: _________________ ID#: ____________________DOB: ___/___/___

Insurance Company: _______________________________ Phone No: ____________________

Insurance Company Address: ____

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

☐yes ☐no Started teething very early or late?
☐yes ☐no Any teeth removed for any reason?
☐yes ☐no Supernumerary (extra) or congenitally missing teeth?
☐yes ☐no Chipped or otherwise injured primary (baby) or permanent teeth?
☐yes ☐no Teeth sensitive to hot or cold; teeth throb or ache?
☐yes ☐no Jaw fractures, cysts or mouth infections?
☐yes ☐no "Dead teeth" or root canals treated?
☐yes ☐no Periodontal problems, bleeding gums, bad taste or mouth odor?
☐yes ☐no Thumb, finger, or sucking habit? Until what age _____?
☐yes ☐no Abnormal swallowing habit (tongue thrusting)?
☐yes ☐no History of speech problems?
☐yes ☐no Mouth breathing habit, snoring or difficulty in breathing?

☐yes ☐no Tooth grinding, jaw clenching clicking or locking?
☐yes ☐no Any pain in jaw or ringing in the ears?
☐yes ☐no Difficulty encountered in chewing or jaw opening?
☐yes ☐no Aware of loose, broken or missing restorations (fillings)?
☐yes ☐no Any teeth irritating cheek, lip, tongue or palate?
☐yes ☐no Frequent canker sores or cold sores?
☐yes ☐no Taking any forms of fluoride?
☐yes ☐no Is patient sensitive or self-conscious about teeth?
☐yes ☐no Ever had a prior orthodontic examination or treatment?

How does patient feel about braces? ______________________________

What concerns you most about his/her teeth? __________________________

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

☐yes ☐no Birth defects or hereditary problems?
☐yes ☐no Bone fractures, any major accidents?
☐yes ☐no Rheumatoid or arthritic conditions?
☐yes ☐no Endocrine or thyroid problems?
☐yes ☐no Kidney problems?
☐yes ☐no Diabetes?
☐yes ☐no Cancer, tumor, radiation treatment or chemotherapy?
☐yes ☐no Stomach ulcer or hyperacidity?
☐yes ☐no Polio, mononucleosis, tuberculosis or pneumonia?
☐yes ☐no Problems of the immune system? AIDS or HIV positive?
☐yes ☐no Hepatitis, jaundice or liver problem?
☐yes ☐no Fainting spells, seizures, epilepsy or neurological problem?
☐yes ☐no Mental health disturbance or behavioral problem?
☐yes ☐no Vision, hearing, tasting or speech difficulties?
☐yes ☐no Loss of weight recently, poor appetite?
☐yes ☐no History of eating disorder (anorexia, bulimia)?
☐yes ☐no Excessive bleeding or bruising tendency, anemia or bleeding disorder?
☐yes ☐no High or low blood pressure?
☐yes ☐no Chest pain, shortness of breath or swelling ankles?
☐yes ☐no Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
☐yes ☐no Skin disorder?
☐yes ☐no Does the patient eat a well-balanced diet?
☐yes ☐no Frequent headaches, colds or sore throats?
☐yes ☐no Eye, ear, nose or throat condition?
☐yes ☐no Hayfever, asthma, sinus trouble or hives?
☐yes ☐no Tonsil or adenoid conditions?

Circle allergies or reactions to any of the following:

Local anesthetics (Novocaine)	Codeine or other narcotics
Aspirin	Ibuprofen (Motrin, Advil)
Penicillin or other antibiotics	Sulfa drugs
Metals (jewelry)	Latex (gloves, balloons)
Vinyl, Acrylic, or Animals	Foods (specify)

Please list any medication, nutrient supplements, herbal medications or non prescription medicine being taken by the patient.

Medication ______________________ Taken for ______________________
Medication ______________________ Taken for ______________________
Medication ______________________ Taken for ______________________

☐yes ☐no Current or past substance abuse problem?
☐yes ☐no Does the patient chew or smoke tobacco?
☐yes ☐no Operations or Surgery? Describe: __________________
☐yes ☐no Hospitalized? For:______________________________
☐yes ☐no Being treated by another health care professional?
For:____

Are there any other medical conditions that we should be aware of?

_____

GIRLS ONLY

☐yes ☐no Has the patient started her monthly periods?
If so, approximately when? ___________
☐yes ☐no Is the patient pregnant?

FAMILY MEDICAL HISTORY

List any family medical conditions that we should know about?

How often does your child brush? _____ Floss? _____

I have read and understand the above questions. 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. If there are any changes later to this history record or medical/dental status, I will so inform this practice. Further more, I consent to an orthodontic examination and, if necessary, orthodontic records which include photos, impressions for study models, and two radiographs.

Signed: ____ Date Signed: ______________
(Parent or Guardian)

Signed: ____ Date Signed: ______________
(Dental Staff Member)

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