



**RICHARD CHAN**  
ORTHODONTICS

Date: \_\_\_\_\_

CONFIDENTIAL

**MEDICAL DENTAL HISTORY FORM FOR  
PATIENTS UNDER 18 YEARS OF AGE**

Patient's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

I Prefer To Be Called: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male Female

S.S.N./S.I.N.: \_\_\_\_\_ Home Phone:(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

E-mail address: \_\_\_\_\_

May we use this email address to send you office news and correspondence(Circle One)? Yes No

Cell phone number:(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Pager number:(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Patient's Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

Attends School At: \_\_\_\_\_ Grade: \_\_\_\_\_

Musical Instruments Played: \_\_\_\_\_

Sports And/Or Hobbies: \_\_\_\_\_

No. of brothers and sisters: \_\_\_\_\_ Ages: \_\_\_\_\_

Other family members treated here: \_\_\_\_\_

Birth Father's Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Birth Mother's Height \_\_\_\_\_ ft. \_\_\_\_\_ in.

Patient's Birth Weight \_\_\_\_\_ lbs Patient's Present Weight \_\_\_\_\_ lbs

Patient's Present Height \_\_\_\_\_ ft. \_\_\_\_\_ in.

Custodial Parent(s) or Guardian(s): \_\_\_\_\_

Address (if different than patient's): \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

Email address: \_\_\_\_\_ Cell phone/pager: \_\_\_\_\_



**MEDICAL INFORMATION**

Patient's Dentist/Dental Office: \_\_\_\_\_ Phone:(\_\_\_\_\_) - \_\_\_\_\_

Dentist's Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

Date Last Seen: \_\_\_\_\_ Reason: \_\_\_\_\_

Patient's Physician(s): \_\_\_\_\_ Phone:(\_\_\_\_\_) - \_\_\_\_\_

Physician's Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

Date Last Seen: \_\_\_\_\_ Reason: \_\_\_\_\_

**FINANCIAL INFORMATION**

Who Is Financially Responsible For This Account?

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address (if different than patient's) \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

Phone:(\_\_\_\_\_) - \_\_\_\_\_ How many years at this residence? \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_ How many years? \_\_\_\_\_

Spouse Employer: \_\_\_\_\_ Phone: \_\_\_\_\_ How many years? \_\_\_\_\_

Insurance Coverage For Dental Treatment? Yes No

Insurance Coverage For Orthodontic Treatment? Yes No

Primary Policy Holder's Name: \_\_\_\_\_ S.S.N./S.I.N.: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Employed By: \_\_\_\_\_

Dental Ins Co: \_\_\_\_\_ Phone: \_\_\_\_\_ Group No. \_\_\_\_\_

Secondary Policy Holder's Name: \_\_\_\_\_ S.S.N./S.I.N.: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Employed By: \_\_\_\_\_

Dental Ins Co: \_\_\_\_\_ Phone: \_\_\_\_\_ Group No. \_\_\_\_\_



For the following questions mark yes, no, or don't know/ understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

**PATIENT PROFILE**

- yes no dk/u Does patient follow directions well?
- yes no dk/u Does patient brush his/her teeth conscientiously?
- yes no dk/u Does patient have learning disabilities or need extra help with instructions?
- yes no dk/u Is patient sensitive or self-conscious about teeth?

**MEDICAL HISTORY**

Now or in the past, has the patient had:

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

Allergies or reactions to any of the following:

- yes no dk/u Local anesthetics (Novocaine or Lidocaine)
- yes no dk/u Aspirin
- yes no dk/u Ibuprofen (Motrin, Advil)
- yes no dk/u Penicillin or other antibiotics
- yes no dk/u Sulfa drugs
- yes no dk/u Codeine or other narcotics
- yes no dk/u Metals (jewelry, clothing snaps)
- yes no dk/u Latex (gloves, balloons)
- yes no dk/u Vinyl
- yes no dk/u Acrylic
- yes no dk/u Animals
- yes no dk/u Foods (specify) \_\_\_\_\_
- yes no dk/u Other substances (specify) \_\_\_\_\_
- yes no dk/u Are you currently taking or have you ever taken any intravenous bisphosphonates for serious bone disorders/cancers: such as Zometa (zoledronic acid), Aredia (pamidronate), Didronel (etidronate)?
- yes no dk/u Are you currently taking or have you ever taken any oral bisphosphonates for osteoporosis, osteopenia or other uses: such as Fosamax (alendronate), Actonel (risendronate), Boniva (ibandronate) Skelid (tiludronate), Didronel (etidronate)?
- yes no dk/u Is the patient taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.  
Medication \_\_\_\_\_ Taken for \_\_\_\_\_  
Medication \_\_\_\_\_ Taken for \_\_\_\_\_  
Medication \_\_\_\_\_ Taken for \_\_\_\_\_
- yes no dk/u Does the patient currently have or ever had a substance abuse problem?
- yes no dk/u Does the patient chew or smoke tobacco?
- yes no dk/u Operations? Describe: \_\_\_\_\_
- yes no dk/u Hospitalized? For: \_\_\_\_\_
- yes no dk/u Other physical problems or symptoms?  
Describe: \_\_\_\_\_
- yes no dk/u Being treated by another health care professional?  
For: \_\_\_\_\_
- yes no dk/u Date of most recent physical exam? \_\_\_\_\_

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

**GIRLS ONLY**

- yes no dk/u Has the patient started her monthly periods?  
If so, approximately when? \_\_\_\_\_
- yes no dk/u Is the patient pregnant?



**FAMILY MEDICAL HISTORY**

Do the patient's parents or siblings have any of the following health problems? If so, please explain.

Bleeding disorders \_\_\_\_\_

Diabetes \_\_\_\_\_

Arthritis \_\_\_\_\_

Metabolic disturbances \_\_\_\_\_

Severe allergies \_\_\_\_\_

Unusual dental problems \_\_\_\_\_

Jaw size imbalance \_\_\_\_\_

Any other family medical conditions that we should know about?  
\_\_\_\_\_

**DENTAL HISTORY**

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

- yes no dk/u** Started teething very early or late?
- yes no dk/u** Primary (baby) teeth removed that were not loose?
- yes no dk/u** Permanent or "extra" (supernumerary) teeth removed?
- yes no dk/u** Supernumerary (extra) or congenitally missing teeth?
- yes no dk/u** Chipped or otherwise injured primary (baby) or permanent teeth?
- yes no dk/u** Teeth sensitive to hot or cold; teeth throb or ache?
- yes no dk/u** Jaw fractures, cysts or mouth infections?
- yes no dk/u** "Dead teeth" or root canals treated?
- yes no dk/u** Bleeding gums, bad taste or mouth odor?
- yes no dk/u** Periodontal "gum problems"?

- yes no dk/u** Food impaction between teeth?
- yes no dk/u** Thumb/finger/sucking habit? Until age \_\_\_\_\_?
- yes no dk/u** Abnormal swallowing habit (tongue thrusting)?
- yes no dk/u** History of speech problems?
- yes no dk/u** Mouth breathing habit, snoring or difficulty in breathing?
- yes no dk/u** Tooth grinding, jaw clenching clicking or locking?
- yes no dk/ u** Any pain in jaw or ringing in the ears?
- yes no dk/u** Any pain or soreness in the muscles of the face or around the ears?
- yes no dk/u** Difficulty encountered in chewing or jaw opening?
- yes no dk/u** Aware of loose, broken or missing restorations (fillings)?
- yes no dk/u** Any teeth irritating cheek, lip, tongue or palate?
- yes no dk/u** Concerned about spaced, crooked or protruding teeth?
- yes no dk/u** Aware or concerned about under or over developed jaw?
- yes no dk/u** "Gum Boils", frequent canker sores or cold sores?
- yes no dk/u** Taking any forms of fluoride?
- yes no dk/u** Any relative with similar tooth or jaw relationships?
- yes no dk/u** Had periodontal (gum) treatment?
- yes no dk/u** Would patient object to wearing orthodontic appliances (braces) should they be indicated?
- yes no dk/u** Any serious trouble associated with any previous dental treatment?
- yes no dk/u** Ever had a prior orthodontic examination or treatment?
- yes no dk/u** Been under another dentist's care?  
Specialist \_\_\_\_\_  
Other \_\_\_\_\_

How often does your child brush? \_\_\_\_\_ Floss? \_\_\_\_\_

What is your primary concern? Why are you here? \_\_\_\_\_

Who may we thank for your referral?: \_\_\_\_\_

Why did you select our office? \_\_\_\_\_

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. I also understand that, where appropriate, credit bureau reports may be obtained and will be kept confidential.

Signed: \_\_\_\_\_ Date Signed: \_\_\_\_\_  
(Parent or Guardian)

Signed: \_\_\_\_\_ Date Signed: \_\_\_\_\_  
(Dental Staff Member)