DRO **Drake Road**
ORTHODONTICS

MEDICAL DENTAL HISTORY

CONFIDENTIAL

PATIENT

Date ____ / ____ /____ First name ____ Last name ____ Middle initial ____

Prefers To Be Called ____ Birth date ____ / ____ / ____

Age ____ Sex: ☐ Male ☐ Female Occupation ____

School (CHILD ONLY) ____ Grade ____ Hobbies ____

Home address ____ City ____ State ____ Zip code ____

Home phone (____) ____-____ Cell phone (____) ____ - ____ E-mail/s ____

PARENT/GUARDIAN (CHILD ONLY)

Parent's full name ____

Occupation ____ Email address ____

Address (if different) ____ City ____ State ____ Zip code ____

Home phone (if different) (____) ____-____ Cell (____) ____ - ____ Work (____) ____ - ____

Parent's full name ____

Occupation ____ Email address ____

Address (if different) ____ City ____ State ____ Zip code ____

Home phone (if different) (____) ____-____ Cell (____) ____ - ____ Work (____) ____ - ____

Patient lives with ____

CLOSEST RELATIVE (SKIP IF UNDER 18)

Spouse or closest relative's name(s) ____ Relationship to patient ____

Home address ____ City ____ State ____ Zip code ____

Home phone (____) ____-____ Cell (____) ____ - ____ Work (____) ____ - ____

DENTIST

Patient's Dentist ____

City, State ____ Last appt ____ /____ Reason ____ Next appt ____ /____

Other dentists/dental specialists:

Name ____ City, State ____ Last appt ____ /____

Reason ____ Next appt ____ /____

PHYSICIAN

Patient's Physician _____ City, State _____ Last seen _____ /_____

Reason _____ Next appointment _____ /_____ Most recent physical exam _____ /_____

Other physicians/health care providers being seen now:

Name _____ City, State _____ Name _____ City, State _____

Reason _____ Reason _____

GENERAL INFORMATION

What concerns do you/your child have about their teeth? _____

How does the patient feel about orthodontic treatment? _____

Who suggested orthodontic treatment? _____ Why did you select our office? _____

Describe any previous orthodontic treatment or consultations _____

Please list any work or leisure activities that may affect your teeth _____

Have any other family members been treated in this office? _____

(For Kids Only) Please list all siblings, and if they have had orthodontic treatment here or elsewhere _____

_____

_____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____

Home address _____ City _____ State _____ Zip code _____

Home phone (_____) _____-_____ Cell (_____) _____ - _____ Work (_____) _____ - _____

Social Security #_____ -_____ -_____ Employer _____

Who will be bringing the patient to orthodontic appointments? _____

DENTAL INSURANCE

Primary policy holder's full name _____ Birth date _____ / _____ /_____

Social Security #_____ -_____ -_____ Relationship to patient _____

Address **(if different)** _____ City _____ State _____ Zip code _____

Home phone **(if different)** (_____) _____-_____ Cell (_____) _____ - _____ Employer _____

Insurance company _____ Group # _____ ID # _____

Does this policy have orthodontic benefits? __ yes __no __don't know

Secondary policy holder's full name _____ Birth date _____ / _____ /_____

Social Security #_____ -_____ -_____ Relationship to patient _____

Address **(if different)** _____ City _____ State _____ Zip code _____

Home phone **(if different)** (_____) _____-_____ Cell (_____) _____ - _____ Employer _____

Insurance company _____ Group # _____ ID # _____

Does this policy have orthodontic benefits? __ yes __ no __ don't know

PATIENT HISTORY

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation.

FOR THE FOLLOWING QUESTIONS, PLEASE MARK YES OR NO.

MEDICAL HISTORY

__ yes __ no Birth defects or hereditary problems

__ yes __ no Bone fractures, or major injuries

__ yes __ no Any injuries to face, head, neck

__ yes __ no Arthritis or joint problems

__ yes __ no Cancer, tumor, radiation treatment or chemotherapy

__ yes __ no Endocrine or thyroid problems

__ yes __ no Diabetes or low sugar

__ yes __ no Kidney problems

__ yes __ no Immune system problems

__ yes __ no History of osteoporosis

__ yes __ no Gonorrhea, syphilis, herpes, STDs

__ yes __ no AIDS or HIV positive

__ yes __ no Hepatitis, jaundice or other liver problems

__ yes __ no Polio, mononucleosis, tuberculosis, pneumonia

__ yes __ no Seizures, fainting spells, neurological problem

__ yes __ no Mental health disturbance or depression

__ yes __ no History of eating disorder (anorexia, bulimia)

__ yes __ no Frequent headaches or migraines

__ yes __ no High or low blood pressure

__ yes __ no Excessive bleeding or bruising tendency, anemia

__ yes __ no Chest pain, shortness of breath, tire easily, swollen ankles

__ yes __ no Heart defects, heart murmur, rheumatic heart disease

__ yes __ no Angina, arteriosclerosis, stroke or heart attack

__ yes __ no Skin disorder (other than common acne)

__ yes __ no Do you (or does your child) eat a well-balanced diet

__ yes __ no Vision, hearing, or speech problems

__ yes __ no Frequent ear infections, colds, throat infections

__ yes __ no Asthma, sinus problems, hayfever

__ yes __ no Tonsil or adenoid condition

__ yes __ no Frequently breathe through mouth

__ yes __ no Taken intravenous bisphosphonatessuch as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?

__ yes __ no Taken oral bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders?

ALLERGIES OR REACTIONS

__ yes __ no Local anesthetics (novocaine, lidocaine, xylocaine)

__ yes __ no Latex (gloves, balloons)

__ yes __ no Aspirin

__ yes __ no Ibuprofen (Motrin, Advil)

__ yes __ no Penicillin

__ yes __ no Other antibiotics _____

__ yes __ no Metals (jewelry, clothing snaps)

__ yes __ no Acrylics

__ yes __ no Plant pollens

__ yes __ no Animals _____

__ yes __ no Foods _____

__ yes __ no Other substances _____

DENTAL HISTORY

__ yes __ no Erupting teeth very early or very late

__ yes __ no Primary (baby) teeth removed that were not loose

__ yes __ no Permanent or extra (supernumerary) teeth removed

__ yes __ no Supernumerary (extra) or congenitally missing teeth

__ yes __ no Chipped or injured primary or permanent teeth

__ yes __ no Any sensitive or sore teeth

__ yes __ no Bleeding gums, bad taste or mouth odor

__ yes __ no Any lost or broken fillings

__ yes __ no Jaw fractures, cysts, infections

__ yes __ no Any teeth treated with root canals or pulpotomies

__ yes __ no Frequent canker sores or cold sores

__ yes __ no History of speech problems or speech therapy

__ yes __ no Difficulty breathing through nose

__ yes __ no Food impaction between teeth

__ yes __ no Mouth breathing habit or snoring at night

__ yes __ no History of speech problems

__ yes __ no Oral habits (sucking finger, chewing pen, etc.)

__ yes __ no Teeth causing irritation to lip, cheek or gums

__ yes __ no Tooth grinding or clenching

__ yes __ no Clicking, locking in jaw joints

__ yes __ no Soreness in jaw muscles or face muscles

__ yes __ no Ringing in ears, difficulty chewing or opening jaw

__ yes __ no Treated for “TMJ” or “TMD” problems

__ yes __ no Any broken or missing fillings

__ yes __ no Serious trouble with previous dental treatment

__ yes __ no Ever been diagnosed with gum disease or pyorrhea

PATIENT HEALTH INFORMATION

Please list any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements.

Medication _____ Taken for _____

Medication _____ Taken for _____

__ yes __ no Do you take antibiotic pre-medication before any dental procedures?

__ yes __ no Does the patient currently have (or ever had) a substance abuse problem? _____

__ yes __ no Do you/your child chew or smoke tobacco?

__ yes __ no Have you noticed any unusual changes in you/your child's face or jaws? _____

__ yes __ no Are you pregnant? __ yes __ no Are you trying to become pregnant?

How often do you brush? _____ How often do you floss? _____

Any other physical problems? _____

FAMILY MEDICAL HISTORY

Has the patient's parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders _____

Diabetes _____

Arthritis _____

Severe allergies _____

Unusual dental problems/ Jaw size imbalance _____

Other family medical conditions? _____

RELEASE AND WAIVER

I authorize release of any information regarding my/my child's orthodontic treatment to my dental and/or medical insurance company.

SIGNATURE _____ **Date** ____ / ____ / ____

I have read the above questions and understand them. 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. I will notify my orthodontist of any changes in my/my child's medical or dental health.

SIGNATURE _____ **Date** ____ / ____ / ____

STAFF SIGNATURE _____ **Date** ____ / ____ / ____

MEDICAL HISTORY UPDATES

Change _____

SIGNATURE _____ **Date** ____ / ____ / ____

STAFF SIGNATURE _____ **Date** ____ / ____ / ____

Change _____

SIGNATURE _____ **Date** ____ / ____ / ____

STAFF SIGNATURE _____ **Date** ____ / ____ / ____