SMILE BRITE ORTHODONTICS

Medical - Dental History Form

Date _____

PATIENT

Patient's Last name _____ First name _____ Middle initial _____

Birth date _____ Sex: Male Female Social Security # _____ - _____ - _____

Home address _____ City, State, Zip code _____

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

PARENT/GUARDIAN (Complete This Section if Patient is a Minor)

Patient Prefers To Be Called _____ Hobbies, activities _____

School _____ Grade _____

Does your child play a musical instrument?_____Which one?_____

Custodial parent(s) name (s) _____

Patient lives with (*Circle all that apply*) mother father stepmother stepfather grandparent(s) other _____

Parent 1) full name _____ Title Mr. Ms. Dr. Other _____

Occupation _____ Email address _____

Address (*if different from above*) _____

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

Parent 2) full name _____ Title Mr. Ms. Dr. Other _____

Occupation _____ Email address _____

Address (*if different from above*) _____

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

DENTIST

Patient's Dentist _____ Address, City, State _____

Last dental visit _____ Reason _____ Next appointment _____

Other dentists/dental specialists now being seen: Name _____ City _____Reason _____

GENERAL INFORMATION

What would you like to change about your *or* your child's smile? _____

Who may we thank for your referral to Smile Brite Orthodontics? _____

Describe any previous orthodontic treatment or consultations. _____

Have any other family members been treated in this office? _____Please name them. _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____

Address (*if different from patient's address*) _____City, State, Zip _____

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

E-mail address(es) _____ Social Security # _____- _____ - _____

Employer:_____

Who will be responsible for bringing the patient (if minor) to orthodontic appointments? _____

DENTAL INSURANCE

Primary policy holder's full name _____ Birth date _____

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

Address and phone (if not listed above) _____

Employer _____ Address _____

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 and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID # _____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't know

PATIENT HEALTH INFORMATION

Is Patient Pregnant? _____

Has patient received trauma to face or teeth due to injury? _____

List any medication, supplements, herbal medications or non- prescription medicines taken by patient.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Do you take antibiotic pre -medication before any dental procedures? ☐ Yes ☐ No

Does the patient currently have (or ever had) a substance abuse problem? _____

Does patient chew or smoke tobacco? _____

How often does patient brush? _____

Floss? _____

Other physicians/he alth care providers being seen now:

Name _____ City, State _____

Reason _____

Name _____ City, State _____

Reason _____

FAMILY MEDICAL HISTORY

Have the 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? _____

Patient's Name _____ Date of Birth _____

For the following questions, please mark yes, no, or don't know/understand (dk/u).

MEDICAL HISTORY

Now or in the past, has Patient had:

- ☐yes ☐no ☐dk/u Birth defects or hereditary problems?
- ☐yes ☐no ☐dk/u Bone fractures, or major injuries ?
- ☐yes ☐no ☐dk/u Any injuries to face, head, neck?
- ☐yes ☐no ☐dk/u Arthritis or joint problems ?
- ☐yes ☐no ☐dk/u Cancer, tumor, radiation treatment or chemotherapy?
- ☐yes ☐no ☐dk/u Endocrine or thyroid problems?
- ☐yes ☐no ☐dk/u Diabetes or low sugar ?
- ☐yes ☐no ☐dk/u Kidney problems ?
- ☐yes ☐no ☐dk/u Immune system problems ?
- ☐yes ☐no ☐dk/u History of osteoporosis ?
- ☐yes ☐no ☐dk/u Gonorrhea, syphilis, herpes, sexually transmitted diseases ?
- ☐yes ☐no ☐dk/u AIDS or HIV positive?
- ☐yes ☐no ☐dk/u Hepatitis, jaundice or other liver problems?
- ☐yes ☐no ☐dk/u Polio, mononucleosis, tuberculosis, pneumonia?
- ☐yes ☐no ☐dk/u Seizures, fainting spells, neurologic problem?
- ☐yes ☐no ☐dk/u Mental health disturbance or depression?
- ☐yes ☐no ☐dk/u History of eating disorder (anorexia, bulimia)?
- ☐yes ☐no ☐dk/u Frequent headaches or migraines?
- ☐yes ☐no ☐dk/u High or low blood pressure?
- ☐yes ☐no ☐dk/u Excessive bleeding or bruising tendency, anemia?
- ☐yes ☐no ☐dk/u Chest pain, shortness of breath, tire easily, swollen ankles?
- ☐yes ☐no ☐dk/u Heart defects, heart murmur, rheumatic heart disease?
- ☐yes ☐no ☐dk/u Angina, arteriosclerosis, stroke or heart attack?
- ☐yes ☐no ☐dk/u Skin disorder (other than common acne) ?
- ☐yes ☐no ☐dk/u Surgeries Performed ?
- ☐yes ☐no ☐dk/u Vision, hearing, or speech problems ?
- ☐yes ☐no ☐dk/u Frequent ear infections, colds, throat infections ?
- ☐yes ☐no ☐dk/u Asthma, sinus problems, hayfever ?
- ☐yes ☐no ☐dk/u Tonsil or adenoid condition?
- ☐yes ☐no ☐dk/u Does patient frequently breathe through his/her mouth?
- ☐yes ☐no ☐dk/u Has patient ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?
- ☐yes ☐no ☐dk/u Has patient ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders?

Has Patient had allergies or reactions to any of the following?

- ☐yes ☐no ☐dk/u Local anesthetics (novocaine, lidocaine, xylocaine)
- ☐yes ☐no ☐dk/u Latex (gloves, balloons)
- ☐yes ☐no ☐dk/u Aspirin
- ☐yes ☐no ☐dk/u Ibuprofen (Motrin, Advil)
- ☐yes ☐no ☐dk/u Penicillin
- ☐yes ☐no ☐dk/u Other antibiotics
- ☐yes ☐no ☐dk/u Metals (jewelry, clothing snaps)
- ☐yes ☐no ☐dk/u Acrylics
- ☐yes ☐no ☐dk/u Plant pollens
- ☐yes ☐no ☐dk/u Animals
- ☐yes ☐no ☐dk/u Foods
- ☐yes ☐no ☐dk/u Other substances

DENTAL HISTORY

Now or in the past, has the patient had:

- ☐yes ☐no ☐dk/u Erupting teeth very early or very 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 injured primary or permanent teeth?
- ☐yes ☐no ☐dk/u Any sensitive or sore teeth?
- ☐yes ☐no ☐dk/u Any lost or broken fillings?
- ☐yes ☐no ☐dk/u Jaw fractures, cysts, infections?
- ☐yes ☐no ☐dk/u Any teeth treated with root canals or pulpotomies?
- ☐yes ☐no ☐dk/u Frequent canker sores or cold sores?
- ☐yes ☐no ☐dk/u History of speech problems or speech therapy?
- ☐yes ☐no ☐dk/u Difficulty breathing through nose?
- ☐yes ☐no ☐dk/u Mouth breathing habit or snoring at night?
- ☐yes ☐no ☐dk/u History of speech problems?
- ☐yes ☐no ☐dk/u Frequent oral habits (sucking finger, chewing pen, etc.)?
- ☐yes ☐no ☐dk/u Teeth causing irritation to lip, cheek or gums?
- ☐yes ☐no ☐dk/u Tooth grinding or clenching?
- ☐yes ☐no ☐dk/u Clicking, locking in jaw joints?
- ☐yes ☐no ☐dk/u Soreness in jaw muscles or face muscles?
- ☐yes ☐no ☐dk/u Has your child been treated for "TMJ" or "TMD" problems?
- ☐yes ☐no ☐dk/u Any broken or missing fillings?
- ☐yes ☐no ☐dk/u Any serious trouble associated with previous dental treatment?
- ☐yes ☐no ☐dk/u Has patient ever been diagnosed with gum disease or pyorrhea?

RELEASE AND WAIVER

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

Patient / Parent (if minor)/ Guardian 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 Patient's medical or dental health.

Patient / Parent (if minor)/ Guardian Signature : _____ Date : _____