Zweihorn ORTHODONTICS

Member American Association of Orthodontists
My Life. My Smile. My Orthodontist.®

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

CONFIDENTIAL Date: _____

Please Complete All Fields. If Not Applicable, Please Write N/A

Patient's Last Name: _____ First Name: _____ Middle Name/Initial: ____

Prefers To Be Called: _____ Birth Date: _____ Age: ___ Sex: Male __ Female __

Home Phone No.: ( ) ____-_____ Cell Phone: ( ) ____-_____

Patient's Address: _____ City: _____ State: _____ Zip Code: _____

Attends School At: _____ Grade: _____

Musical Instruments Played: _____Sports/Hobbies: _____

Other Family Members Treated Here: _____

Custodial Parent(s) or Guardian(s): _____Relationship to Patient_____

Home Phone No: ( ) ____-_____ Cell No.: ( ) ____-_____ E-mail address: _____

Name Of Patient's Dentist: _____ Phone No.: ( ) ____-_____

Who Is Financially Responsible For This Account?

Last Name: _____ First Name: _____ Middle Name/Initial: ___

Address: _____ Occupation: _____ Employer: _____

Years at current work: ___ Home Phone No.: ( ) ____-_____ Work Phone: ( ) ____-_____

Insurance Coverage For Dental Treatment? Yes __ No __

Insurance Coverage For Orthodontic Treatment? Yes __ No __

Who suggested that your child might need orthodontic treatment? _____

How did you select our office?

- o Dentist Referred _____
- o Friend Referred _____
- o Saw the Sign
- o Other _____

I certify that the above information is true and accurate to my knowledge:_____

Authorization of Benefits

I hereby authorize direct payment of the dental benefits otherwise payable to me, directly to Zweihorn Orthodontics.

_____ _____ _____

Signature – Subscriber Date Office Staff Date

Please also complete the health history on the other side of this page.

A thorough health history is essential to a complete orthodontic evaluation. Your answers are for office records only, and are confidential. For the following questions, please mark *yes, no*, **or** *don't know/don't understand (dk/u).*

MEDICAL HISTORY

Now or in the past, have you any:

☐**yes** ☐**no** ☐**dk/u** Birth defects or hereditary problems?
☐**yes** ☐**no** ☐**dk/u** Bone fractures, or 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 blood 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** Sexually transmitted disease?
☐**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, 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** Do you eat a well-balanced diet?
☐**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** Have you ever taken bisphosphonates for bone disorders or cancer?

Have you 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** Foods: _____
☐**yes** ☐**no** ☐**dk/u** Other substances: _____

DENTAL HISTORY

Now or in the past, have you any:

☐**yes** ☐**no** ☐**dk/u** Supernumerary (extra) teeth or missing teeth?
☐**yes** ☐**no** ☐**dk/u** Chipped or injured teeth?
☐**yes** ☐**no** ☐**dk/u** Sensitive or sore teeth?
☐**yes** ☐**no** ☐**dk/u** Jaw fractures, cysts, infections?
☐**yes** ☐**no** ☐**dk/u** Teeth treated with root canals or pulpotomies?
☐**yes** ☐**no** ☐**dk/u** "Gum boils," frequent canker sores or cold sores?
☐**yes** ☐**no** ☐**dk/u** History of speech problems or speech therapy?
☐**yes** ☐**no** ☐**dk/u** Difficulty breathing through the nose? Snoring?
☐**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 jaw clenching?
☐**yes** ☐**no** ☐**dk/u** Clicking, locking, or pain in jaw joints or muscles?
☐**yes** ☐**no** ☐**dk/u** History of "TMJ Problems?"
☐**yes** ☐**no** ☐**dk/u** Broken or missing fillings?
☐**yes** ☐**no** ☐**dk/u** Trouble with previous dental treatment?
☐**yes** ☐**no** ☐**dk/u** History of gum disease?
☐**yes** ☐**no** ☐**dk/u** Orthodontic consultation or treatment before now?

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

PATIENT HEALTH INFORMATION

List all medications, nutritional supplements, herbal medications and non-prescription medicines, including fluoride supplements that you take:

_____

Antibiotic pre-medication before any dental treatment? ☐ Yes ☐ No
Have you any history of substance abuse or a current issue? _____
Do you chew or smoke tobacco? _____
Have you noticed any changes in your face or jaws? _____
Any other physical problems? _____

Women: Are you pregnant? ☐ Yes ☐ No
Are you trying to become pregnant? ☐ Yes ☐ No

FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following health problems?

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 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 the doctor or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I will notify the doctor of any changes in my medical or dental health.

Signature:

_____

Date:_____