RICHMOND ORTHODONTICS

American Association of Orthodontists

CONFIDENTIAL

Medical Dental History Form
For Patients Under Age 18

PATIENT

Date _____ Last name _____ First name _____

Prefers to be called _____ Hobbies, activities _____

Birth date _____ Gender [ ] Male [ ] Female School _____ Grade _____

Home address _____ City, State, Zip _____

Home phone _____ Cell phone _____

PARENT/GUARDIAN

Custodial parent(s) name(s) _____

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

Father's full name _____ Title [ ] Mr [ ] Dr [ ] Other _____

Occupation _____ Email address _____

Address *(if different)* _____

Cell phone _____ Cell phone provider _____ [ ] send text reminder to this number

Mother's full name _____ Title [ ] Mrs [ ] Ms [ ] Dr [ ] Other _____

Occupation _____ Email address _____

Address *(if different)* _____

Cell phone _____ Cell phone provider _____ [ ] send text reminder to this number

DENTIST

Patient's dentist _____

Other dental specialists being seen _____

GENERAL INFORMATION

What concerns you about your child's teeth? _____

What concerns your child about his/her teeth? _____

How does your child feel about orthodontic treatment? _____

Why did you select our office? _____

Who referred you to our office? _____

Describe any previous orthodontic treatment or consultations? _____

Have any other family members been treated in our office? Please name them. _____

Sibling name _____ Age _____ Had orthodontic treatment? [ ] Yes [ ] No Where? _____

Sibling name _____ Age _____ Had orthodontic treatment? [ ] Yes [ ] No Where? _____

Sibling name _____ Age _____ Had orthodontic treatment? [ ] Yes [ ] No Where? _____

MEDICAL AND DENTAL 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, no, or don't know/understand (dk/u).***

Now, or in the past, has your child had:

[ ] yes [ ] no [ ] dk/u Birth defects or hereditary problems?
[ ] yes [ ] no [ ] dk/u Bone fractures or major injuries?
[ ] yes [ ] no [ ] dk/u Cancer, tumor, radiation, chemotherapy?
[ ] yes [ ] no [ ] dk/u Diabetes or low sugar
[ ] yes [ ] no [ ] dk/u History of osteoporosis or bone disorders?
[ ] yes [ ] no [ ] dk/u AIDS or HIV positive?
[ ] yes [ ] no [ ] dk/u Seizures, fainting spells, neurologic problems?
[ ] yes [ ] no [ ] dk/u Mental health disturbances or depression?
[ ] yes [ ] no [ ] dk/u History of eating disorder?
[ ] yes [ ] no [ ] dk/u High or low blood pressure?
[ ] yes [ ] no [ ] dk/u Excessive bleeding, bruising tendency, anemia?
[ ] yes [ ] no [ ] dk/u Heart defects, heart murmur, heart surgery?
[ ] yes [ ] no [ ] dk/u Vision, hearing, speech problems?
[ ] yes [ ] no [ ] dk/u Previous or current use of IV bisphosphonates such as Zometra, Aredia, or Didronel?
[ ] yes [ ] no [ ] dk/u Previous or current use of oral bisphosphonates such as Fosamax, Actonel, Boniva, Skelid, or Didronel?
[ ] yes [ ] no [ ] dk/u Substance abuse problem?
[ ] yes [ ] no [ ] dk/u Tobacco use?

Has your child had allergies or reactions to any of the following?

[ ] yes [ ] no [ ] dk/u Dental local anesthetics (ex lidocaine)
[ ] yes [ ] no [ ] dk/u Latex
[ ] yes [ ] no [ ] dk/u Metals (jewelry, clothing snaps)
[ ] yes [ ] no [ ] dk/u Medications _____

Now, or in the past, has your child had:

[ ] yes [ ] no [ ] dk/u Erupting teeth very early or very late?
[ ] yes [ ] no [ ] dk/u Primary teeth removed that were not loose?
[ ] yes [ ] no [ ] dk/u Permanent or extra teeth removed?
[ ] yes [ ] no [ ] dk/u Supernumerary or congenitally missing teeth?
[ ] yes [ ] no [ ] dk/u Chipped or injured permanent teeth?
[ ] yes [ ] no [ ] dk/u Any sensitive or sore teeth?
[ ] yes [ ] no [ ] dk/u Tooth grinding or clenching?
[ ] yes [ ] no [ ] dk/u History of gum disease
[ ] yes [ ] no [ ] dk/u Jaw fractures, cysts, infections?
[ ] yes [ ] no [ ] dk/u Teeth treated with root canals or pulpotomies?
[ ] yes [ ] no [ ] dk/u History of speech problems, speech therapy?
[ ] yes [ ] no [ ] dk/u Frequent oral habits (ex thumb sucking)?
[ ] yes [ ] no [ ] dk/u Clicking, locking in jaw joints?
[ ] yes [ ] no [ ] dk/u Any injuries to face, hand, neck?

Describe any dental or facial trauma: _____

_____

Is there a family history of jaw size imbalance? _____

_____

Please list any medications or nutritional supplements that your child takes:

Medication	Taken for

Please describe any other pertinent medical history information you would like us to be aware of _____

_____

_____

FINANCIAL RESPONSIBILITY

Please list all individuals who have financial responsibility.

Name	Address *(if not listed on page 1)*	Phone number *(if not listed on page 1)*

DENTAL INSURANCE

[ ] Check here if the patient does not have dental insurance

Primary policy holder's full name _____ Birthdate _____

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 _____ Birthdate _____

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

HIPAA - AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please list any individuals who may bring the patient to their appointments _____

_____

Richmond Orthodontic Specialists is authorized to release information, as indicated, to the following individuals:

Name	Relationship to Patient	Check the Information to Release		
		Any	Clinical	Financial
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

RELEASE AND WAIVER

I have read the above questions and understand them. I will not hold my orthodontist or any member of 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 child's medical or dental health or dental insurance coverage.

I authorize and release any information regarding my child's orthodontic treatment to my dental and/or medical insurance company. I authorize the release of information as listed above in the HIPAA section to the listed individuals. I understand I may revoke this authorization by notifying ROS in writing of my intent to revoke authorization.

I have been offered a copy of the office Notice of Protected Health Information Privacy Practices which is located on the reception room bulletin board.

Parent/Guardian Signature _____ Date _____