PREMIER ORTHODONTICS
Medical Dental History Form for Patients under the age of 18 years

PATIENT INFORMATION

Date: ____________________

Patient's Legal Name: ____
(Last) *(First)* *(Middle)*

Prefers to be called: ___________Date of Birth: ___________ Age: _____ years ____months
Mo. Day Yr.

Patient's Address: ____
(Street) *(City)* *(Zip)*

Home phone: ________________ Patient lives with: ( ) Both Parents Together ( ) Father Primarily ( ) Mother Primarily

Is orthodontic insurance available? ( )None ( )Father ( ) Mother ( )Both ( ) Step-Father ( ) Step-Mother

Patient's Dentist: ____________________ **You were recommended to our office by:**________________________

FAMILY INFORMATION

Father: ____
(Last Name) *(First Name)* *(Middle Initial)*

Social Security Number*: _____________________________ Date of Birth: _______________________________

Address *(if different from patient's):* ____

Home Phone *(if different from patient's):* ____________________Cell: ________________ Carrier: ______________

Work Phone: ________________________ Email: ____

Occupation: ____________________________________ Employer: ___________________________________

Name of Dental Insurance Company: ____________________ *(Please give dental card to receptionist to copy for file.)*

Mother: ____
(Last Name) *(First Name)* *(Middle Initial)*

Social Security Number*: ______________________________ Date of Birth: ______________________________

Address *(if different from patient's):* ____

Home Phone *(if different from patient's):* ____________________Cell: ________________ Carrier: ______________

Work Phone: __________________________________ Email: ____

Occupation: _____________________________ Employer: ____

Name of Dental Insurance Company: ____________________ *(Please give dental card to receptionist to copy for file.)*

*For insurance purposes

PERSON RESPONSIBLE OF ACCOUNT

Check one: ( ) Parents ( ) Split Bill Between Parents ( ) Father Only ( ) Mother Only ( ) Guardian

AUTHORIZATION

I consent to the orthodontist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment and for those activities and health care operations that are related to treatment or payment. I acknowledge that I have had an opportunity to review the office privacy notice and I am in agreement with the office privacy practices.

I consent to the disclosure of my records, treatment information, appointments, etc. (or my child's) to the following persons who are involved in my care (or my child's care) or payment for that care (i.e. step-parent, grand-parent). My consent to disclosure of records shall be effective until I revoke it in writing.

______________________ ______________________ ______________________ ______________________

Print Name **Relationship to Patient** **Print Name** **Relationship to Patient**

I hereby authorize payment of the orthodontic insurance benefits to be made directly to Premier Orthodontics. I understand that I am responsible for all costs of diagnosis and treatment not paid by the insurance company. I hereby authorize the orthodontic office to administer and perform such diagnostic and treatment procedures as may be necessary for proper orthodontic care. The information on this page and the medical history are correct to the best of my knowledge. I will notify the orthodontist of any changes in my child's medical or dental health.

SIGNATURE OF RESPONSIBLE PARTY

X ____ Date: ______________

( ) Father *( ) Mother* *( ) Guardian*

HEALTH HISTORY and PATIENT INFORMATION

Your careful and completed answers to the following questions will be very helpful in the evaluation of your orthodontic problem

PATIENT'S NAME: ____ **DATE**: ____________________

Child's physician: ________________________Address: ____

Date of last medical examination: _______________________ Results: _______________________________________

Height: ____________ Weight: ____________ Present Health? Good __________ Fair __________ Poor __________

Any history of a major illness? Yes __________ No ______________

Has the patient been under the care of a physician during the past two years other than for routine examination? Yes/ No

***Check any of the following for which the patient has been treated*:**

Diabetes	______	Heart problems	______	Bone disorders	______
Hepatitis	______	Bleeding disorders	______	Joint pain	______
Anemia	______	Ear infections	______	Headaches	______
Epilepsy	______	Hormone disorders	______	Convulsions	______
Aids / HIV	______	Sinus infections	______	Dizziness	______
Allergies	______	Asthma / Hay fever	______	Arthritis	______

If you answered yes to any of these questions, please explain:____
____
____

Does patient vomit, gag, or faint easily? Yes ____ No ____

Does patient have tendency for colds? ____ sore throats? ____ ear infections? ____ Yes ____ No ____

Have tonsils and adenoids been removed? What age? ________

List any allergies or drug sensitivity: ____
____

Present drugs or medications being taken: ____

Does patient have arthritis or pain in any joints of the body? Yes ____ No ____

Has the patient ever been treated for mental stress, nerves or any emotional problem? Yes ____ No ____

How many times a week does the patient have a headache? None ___ Few ___ Many ____

How many times a week does the patient take Aspirin, Tylenol or other pain medications? None ___ Few ___ Many ____

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Has the patient reached puberty? Yes ____ No ____

Approximate increase in height in the last 6 months _____ inches.

DENTAL HISTORY

Has the patient had any injury of any type to the face, teeth, chin, or jaws? Yes ____ No ____

Give details of any injuries: ____
____

Has the patient been involved in any automobile, bike, skateboard, swimming pool, or any other sporting accident? Yes ___ No ____

Give details of any injuries: ____
____

Has patient ever had any pain in the jaw joints? Yes ____ No ____

Has patient ever had any clicking or popping sounds from the jaw joints? Yes ____ No ____

Has patient ever had a time when the jaw couldn't open or close? Yes ____ No ____

Has the patient had any muscle pain, tiredness or stiffness of the jaw or neck? Yes ____ No ____

Does the patient grind or clench teeth? While awake? _____ While asleep? _____ Yes ____ No ____

Has the patient had any problems with sore or bleeding gums? Yes ____ No ____

Does the patient have any speech problems? Yes ____ No ____

Does the patient play a musical instrument? Yes ____ No ____

Are there any parts of the mouth or any teeth that are sore to pressure or irritants? (cold, hot, sweets, biting hard foods etc.) Yes ____ No ____

Has the patient had any unusual dental experiences? Yes ____ No ____

Specify: ____

Are there any medical, dental or surgical problems not covered above? Yes ____ No ____

Specify: ____

The following are some habits of interest to Dr. Quraishi. List information as it pertains to the patient.

Thumb sucking until age	____ years	Tongue thrusting	Yes ____ No ____
Finger sucking until age	____ years	Mouth breathing	Yes ____ No ____
Lip biting or lip sucking	Yes ____ No ____	Nail biting	Yes ____ N0 ____
Other habits	Yes ____ No ____	Please explain:	________________________________

(PLEASE COMPLETE THE OTHER SIDE)

PATIENT'S ATTITUDE TOWARD TEETH, FACE AND ORTHODONTIC TREATMENT:

What are the patient's or parent's main concerns regarding the jaws and teeth?

Crowding	___	Deep bite	___	"Buck teeth"	___	Receding jaw	___
Spaces	___	Open bite	___	"Under bite"_	___	Prominent jaw	___
Neck pain	___	Gum disease	___	Clicking jaw	___	Headaches	___
Jaw pain	___	Gummy smile	___	Missing teeth	___	Face proportions	___
Overbite	___	Shape of teeth	___	Habits	___	Others __________________	

Orthodontic consultation prompted by:
Dentist ____ Patient ____ Mother ____ Father ____
Physician ____ Friend ____ Sibling ____ Spouse ____
Other (specify) ____

Patient's interest in orthodontic treatment and braces:
Wants treatment ___ Treatment if necessary ___
Unwilling but agrees ___ Uncooperative ___

Was patient aware of any orthodontic problem? Yes ____ No ____

Patient brushes teeth:
Several times a day ___ Nearly every day ___ Rarely ___
Once a day ___ Occasionally ___ Never ___

Dental check-ups:
Twice a year ___ Once a year ___ Only if urgent ___ Never ___

Date of last dental check-up: _______________ Dr. __________________ Next visit? _______________

Has the dentist ever placed the patient on an oral hygiene program? Yes ____ No ____

Has the patient had deciduous (baby) teeth or permanent teeth removed or extracted? Yes ____ No ____

Are there other family members with a similar orthodontic condition? Yes ____ No ____
Mother ____ Father ____ Sister ____ Brother ____

Has anyone in the family had orthodontic treatment? Yes ____ No ____
Mother ____ Father ____ Sister ____ Brother ____

Has the patient had a previous orthodontic consultation and / or treatment? Yes ____ No ____
When: _______________________ Dr.: ________________________

What school subject does the patient like best? ____

What are the patient's favorite hobbies, sports, or pastimes? ____
____

Are you aware that appointments will infringe on school time? Yes ____ No ____

Do you wish to talk to the orthodontist privately about any special problem? Yes ____ No ____

Additional Comments:
____
____

Signature of individual completing this form: ____
Relationship to patient: ________________________

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8860 Zionsville Road, Suite B
Indianapolis IN 46268
(317) 672-2759

www.premierorthoindy.com