MB Orthodontics, PLLC

ADOLESCENT PATIENT INFORMATION

NAME _____ PREFERRED NAME _____

BIRTHDATE _____ AGE _____ GENDER ☐ MALE ☐ FEMALE

ADDRRESS _____

PHONE (home) _____ (cell) _____

SCHOOL _____ GRADE _____

DENTIST _____DATE OF LAST VISIT _____

SIBLINGS (name/DOB) _____

ADOPTED ☐ YES ☐ NO WHOSE FACIAL/DENTAL STRUCTURE DOES PATIENT RESEMBLE? ☐ FATHER ☐ MOTHER

HAS THE PATIENT EVER HAD AN ORTHODONTIC EVALUATION BEFORE? ☐ YES ☐ NO IF SO, WHERE? _____

PARENT/GUARDIAN INFORMATION

*** If parents are separated/divorced, please circle the name of the person who is financially responsible.***

FATHER ☐ Dr. ☐ Mr.

NAME _____ EMAIL _____

ADDRESS (home) _____# OF YEARS @ ADDRESSS _____

PHONE (home) _____ (work) _____ (cell) _____

EMPLOYER _____ # OF YEARS_____ OCCUPATION _____

BIRTHDATE _____ SSN _____

MOTHER ☐ Dr. ☐ Miss ☐ Ms. ☐ Mrs.

NAME _____ EMAIL _____

ADDRESS (home) _____# OF YEARS @ ADDRESSS _____

PHONE (home) _____ (work) _____ (cell) _____

EMPLOYER _____ # OF YEARS_____ OCCUPATION _____

BIRTHDATE _____ SSN _____

ADDITIONAL INFORMATION

WHAT IS YOUR CHIEF CONCERN? _____

WHOM MAY WE THANK FOR REFERRING YOU TO MB ORTHODONTICS? _____

Retention of Documents Relating to Patient Care. By signing this, you understand and agree that is it our policy to scan and store original documents in electronic form. Further, you agree that any agreement bearing a scanned signature, which is printed in electronic form, has the same force and effect as the original document.

NAME _____ **SIGNATURE** _____ **DATE** _____

(OVER)

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).*

MEDICAL HISTORY

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** 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** Does your child 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** Does your child frequently breathe through his/her mouth?
☐**yes** ☐**no** ☐**dk/u** Has your child ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?
☐**yes** ☐**no** ☐**dk/u** Has your child ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders

Has your child 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 your child ever been diagnosed with gum disease or pyorrhea?

PATIENT HEALTH INFORMATION

Do you think that any of your child's activities affect his/her face, teeth or jaws? How? _____

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that your child takes.

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 your child chew or smoke tobacco? _____

Have you noticed any unusual changes in your child's face or jaws? _____

Any other physical problems? _____

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? _____

How often does your child brush? _____

Floss? _____

RELEASE AND WAIVER

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

Parent/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 my child's medical or dental health.

Parent/Guardian Signature _____
Date_____

MEDICAL HISTORY UPDATES

Changes _____
Parent/Guardian Signature _____
Date_____
Dental Staff Signature _____
Date_____

Changes _____
Parent/Guardian Signature _____
Date_____
Dental Staff Signature _____

Date_____

Changes _____
Parent/Guardian Signature _____
Date_____
Dental Staff Signature _____

Date_____