Rock Street
Pediatric Dentistry
and Orthodontics

Medical Dental History Form

All lines must be completed. Please ask front desk if you have any questions.

PATIENT

First Name _____ Last Name _____ Sex: Circle M F

Date of Birth _____ Age _____

Home Address _____ City _____ State ___ Zip _____

Mailing Address _____ City _____ State ___ Zip _____

Cell _____ Email _____ I consent to receiving text confirmations: Y N

PATIENT/GUARDIAN

Person financially responsible, First Name _____ Last Name _____

Address (if Different) _____ City _____ State ___ Zip _____

Cell _____ Email _____ I consent to receiving text confirmations: Y N

Who will be responsible for bringing the patient to orthodontic appointments? _____

DENTIST

Patient's General Dentist _____ City, State _____

Last seen _____ Reason _____

Does the patient have any current activities or dental work in progress? Circle Y N Explain: _____

Other Dental Specialists _____ Reason _____

GENERAL INFORMATION

How did you hear about us? _____

What concerns do you have about the patient's teeth? _____

Hast the patient had any previous orthodontic consults or treatment? _____

DENTAL INSURANCE

Insurance Company _____ Group # _____ ID # _____

Primary policy holders full name _____ Date of Birth _____

Address and phone (if different from above) _____

Employer _____ Address _____

SECONDARY DENTAL INSURANCE (if applicable)

Insurance Company _____ Group # _____ ID # _____

Primary policy holders full name _____ Date of Birth _____

Address and phone (if different from above) _____

Employer _____ Address _____

PHYSICIAN

Patient's Primary Care Physician _____ City, State _____

Last seen _____ Reason _____

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MEDICAL DENTAL HISTORY

(Circle Yes, No, Unaware)

Now or in the past, has the patient had:

Y N U Birth defects, hereditary problems
Y N U Bone fractures, major injuries
Y N U Injuries to face, head, neck
Y N U Arthritis, joint problems
Y N U Cancer, tumor, radiation treatment or chemo
Y N U Endocrine or thyroid problems
Y N U Diabetes, low sugar
Y N U Kidney problems
Y N U Immune system problems
Y N U History of osteoporosis
Y N U Gonorrhea, syphilis, herpes, STI
Y N U AIDS or HIV+
Y N U Hepatitis, jaundice, other liver problems
Y N U Polio, mononucleosis, tuberculosis, pneumonia
Y N U Seizures, fainting spells, neurologic probiems
Y N U Mental health disturbance, depression, anxiety
Y N U History of eating disorder
Y N U Frequent headaches, migraines
Y N U High, low blood pressure
Y N U Excessive bleeding, bruising, anemia
Y N U Chest pain, shortness of breath, fatigue
Y N U Heart defects, heart murmur, rheumatic disease
Y N U Angina, arteriosclerosis, stroke, heart attack
Y N U Skin disorder (other than acne)
Y N U Does your child eat a well balanced diet
Y N U Vision, hearing, speech problems
Y N U Frequent ear infections, colds, throat infections
Y N U Asthma, sinus problems, hay fever
Y N U Tonsil, adenoid condition

Now or in the past, has the patient had:

Y N U Teeth erupting too early, too late
Y N U Baby teeth removed that were not loose
Y N U Adult teeth removed
Y N U Extra teeth, congenitally missing teeth
Y N U Chipped, injured teeth
Y N U Sensitive, sore teeth
Y N U Lost, broken fillings
Y N U Jaw fractures, cysts, infections
Y N U Root canals, pulpotomies
Y N U Frequent canker sores, cold sores
Y N U Speech therapy, speech problems
Y N U Frequent oral habits (finger sucking,chewing pen etc)
Y N U Teeth causing irritation to lip, cheek, gums
Y N U Tooth grinding, clenching
Y N U Clicking, locking in jaw joints
Y N U Soreness in jaw muscles, face muscles
Y N U Previous treatment for TMJ or TMD
Y N U Problems with previous dental treatment
Y N U Previous diagnosis of gum disease, pyorrhea

Has the patient had allergies or reactions to:

Y N U Local anesthetics (novocaine, lidocaine, xylocaine)
Y N U Latex (gloves, balloons)
Y N U Aspirin
Y N U Ibuprofen (Motrin, Advil)
Y N U Penicillin or other antibiotics
Y N U Metals 0ewelry etc)
Y N U Acrylics
Y N U Plant pollens
Y NU Animals
Y N U Foods
Y N U Other allergies_____

OTHER HEALTH INFORMATION

Please list all medications the patient is taking (if more, please provide comprehensive list):

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Y N U Has the patient ever taken oral or Intravenous **Bisphosphonates** to strength bones, for bone disorders, or cancer? Examples such as Zometa (zolendromic acid), Aredia (pamidronate), Didronel (etidronate), Fosamax (alendronate), Actonel (ridendronate), *Boniva* (ibandronate), *Skelid* (tiludronate)

Y N U Does the patient take antibiotic pre-medication before dental procedures?
Y N U Has the patient ever had tonsils or adenoids removed?
Y N U Does the patient frequently breath through his/her mouth?
Y N U Does the patient snore at night?
Y N U Have any parents or siblings of the patient had orthodontic treatment?

RELEASE AND WAIVER

To the best of my knowledge, the above information is accurate and true. I authorize release of any information regarding the patient's orthodontic treatment to my dental insurance company.

Self/Parent/Guardian Signature _____ Date _____

Dental Staff Signature _____ Date _____