American Association of Orthodontists®

CONFIDENTIAL

Medical Dental History Form For Patients of Age 25 and Younger

PATIENT

Date _____ Social Security # _____

Patient's last name _____ First name _____ Middle initial _____

Prefers to be called _____ Hobbies, activities _____

Birth date _____ What sex was the patient assigned on their birth certificate? ☐ Male ☐Female

What is the patient's current gender identification? ☐Male ☐Female ☐Other

What are the patient's preferred pronouns? _____ School _____ Grade _____

E-mail address(es) _____

Home address _____ City, State, Zip code _____

Home phone _____ Cell phone _____

PARENT/GUARDIAN

Custodial parent(s) name(s) _____

Patient lives with (check all that apply) ☐Parent 1/Guardian ☐Parent 2/Guardian ☐Parent 3/Guardian ☐Parent 4/Guardian

☐ Other. If other, what is the relationship?_____

Parent 1/Guardian full name _____

Occupation_____ E-mail address _____

Address *(if different)* _____

Cell phone *(if different)* _____ Home phone _____ Work phone _____

Parent 2/Guardian full name _____

Occupation_____ E-mail address _____

Address *(if different)* _____

Cell phone *(if different)* _____ Home phone _____ Work phone _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____

Address *(if different than page 1)* _____ City, State, Zip _____

Cell phone _____ Home phone _____ E-mail address(es) _____

Social Security # _____ Employer _____

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

DENTAL INSURANCE

Primary policy holder's full name _____ Birth date _____

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 _____ Birth date _____

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

PHYSICIAN

Patient's Physician _____ City, State _____

Last seen _____ Reason _____ Next appointment _____

Most recent physical exam _____

Other physicians/health care providers being seen now:

Name _____ City, State _____ Reason _____

Name _____ City, State _____ Reason _____

Name _____ City, State _____ Reason _____

DENTIST

Patient's Dentist _____ Address, City, State _____

Last seen _____ Reason _____ Next appointment _____

Other dentists/dental specialists now being seen: Name _____ City, State _____

Reason _____

GENERAL INFORMATION

What concerns you about your child's teeth? _____

What concerns your child about his/her/their teeth? _____

How does your child feel about orthodontic treatment? _____

Who suggested that your child might need orthodontic treatment? _____

Why did you select our office? _____

Describe any previous orthodontic treatment or consultations. _____

Does your child play a musical instrument? _____

Sibling name _____ age ____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Sibling name _____ age ____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Sibling name _____ age ____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Sibling name _____ age ____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

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

PATIENT HEALTH INFORMATION

Does the patient take antibiotic pre-medication before any dental procedures? ☐ Yes ☐ No

Does the patient currently have (or ever had) a substance abuse problem? _____

Do you think that any of your child's activities affect his/her/their 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 _____

Does your child chew or smoke tobacco? _____

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

Any other physical problems? _____

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, mark yes, no, or don't know/understand (dl/u).

DENTAL HISTORY

Now or in the past, has your child had:

Yes No DK/U

☐ ☐ ☐ Erupting teeth very early or very late?
☐ ☐ ☐ Primary (baby) teeth removed that were not loose?
☐ ☐ ☐ Permanent or extra (supernumerary) teeth removed?
☐ ☐ ☐ Supernumerary (extra) or congenitally missing teeth?
☐ ☐ ☐ Chipped or injured primary or permanent teeth?
☐ ☐ ☐ Any sensitive or sore teeth?
☐ ☐ ☐ Any lost or broken fillings?
☐ ☐ ☐ Jaw fractures, cysts, infections?
☐ ☐ ☐ Any teeth treated with root canals or pulpotomies?
☐ ☐ ☐ Frequent canker sores or cold sores?
☐ ☐ ☐ History of speech problems or speech therapy?
☐ ☐ ☐ Difficulty breathing through nose?
☐ ☐ ☐ Mouth breathing habit or snoring at night?
☐ ☐ ☐ History of speech problems?

Yes No DK/U

☐ ☐ ☐ Frequent oral habits (sucking finger, chewing pen, etc)?
Current ___ Yes ___ No Age stopped _
☐ ☐ ☐ Frequent habit of tongue thrust?
Current ___ Yes ___ No Age stopped _
☐ ☐ ☐ Frequent habit of fingernail biting?
Current ___ Yes ___ No Age stopped _
☐ ☐ ☐ Frequent habit of lip sucking?
Current ___ Yes ___ No Age stopped _
☐ ☐ ☐ Teeth causing irritation to lip, cheek or gums?
☐ ☐ ☐ Tooth grinding or clenching?
☐ ☐ ☐ Clicking, locking in jaw joints?
☐ ☐ ☐ Soreness in jaw muscles or face muscles?
☐ ☐ ☐ Has your child been treated for "TMJ" or "TMD" problems?
☐ ☐ ☐ Any broken or missing fillings?
☐ ☐ ☐ Any serious trouble associated with previous dental treatment?
☐ ☐ ☐ Has your child ever been diagnosed with gum disease or pyorrhea?

MEDICAL HISTORY

Now or in the past, has your child had:

Yes No DK/U

☐ ☐ ☐ Emotional, sensory or developmental issues?
☐ ☐ ☐ Hereditary or developmental conditions?
☐ ☐ ☐ Bone fractures or major injuries?
☐ ☐ ☐ Any injuries to face, head, neck?
☐ ☐ ☐ Arthritis or joint problems?
☐ ☐ ☐ Cancer, tumor, radiation treatment or chemotherapy?
☐ ☐ ☐ Endocrine or thyroid problems?
☐ ☐ ☐ Diabetes or low sugar?
☐ ☐ ☐ Kidney problems?
☐ ☐ ☐ Immune system problems?

Yes No DK/U

☐ ☐ ☐ History of osteoporosis?
☐ ☐ ☐ Gonorrhea, syphilis, herpes, sexually transmitted diseases?
☐ ☐ ☐ AIDS or HIV positive?
☐ ☐ ☐ Hepatitis, jaundice, or other liver problems?
☐ ☐ ☐ Polio, mononucleosis, tuberculosis, pneumonia?
☐ ☐ ☐ Seizures, fainting spells, neurologic problems?
☐ ☐ ☐ Mental health disturbance or depression?
☐ ☐ ☐ History of eating disorder (anorexia, bulimia)?
☐ ☐ ☐ Frequent headaches or migraines
☐ ☐ ☐ High or low blood pressure?
☐ ☐ ☐ Excessive bleeding or bruising, anemia?

MEDICAL HISTORY *continued*

Yes No DK/U

- ☐ ☐ ☐ Chest pain, shortness of breath, tire easily, swollen ankles?
- ☐ ☐ ☐ Heart defects, heart murmur, rheumatic heart disease?
- ☐ ☐ ☐ Angina, arteriosclerosis, stroke or heart attack?
- ☐ ☐ ☐ Skin disorder (other than common acne)?
- ☐ ☐ ☐ Does your child eat a well-balanced diet?
- ☐ ☐ ☐ Vision, hearing, or speech problems?
- ☐ ☐ ☐ Frequent ear infections, colds, throat infections?
- ☐ ☐ ☐ Asthma, sinus problems, hayfever?
- ☐ ☐ ☐ Tonsil or adenoid condition?
- ☐ ☐ ☐ Does your child frequently breathe through his/her mouth?
- ☐ ☐ ☐ Has your child ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate)?

Yes No DK/U

- ☐ ☐ ☐ Has your child ever taken oral medication for bone disorders or cancer such as bisphosphonates such as Fosamax (alendronate), Actonel(ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate)?

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

Yes No DK/U

- ☐ ☐ ☐ Local anesthetics (novocaine, lidocaine, xylocaine)
- ☐ ☐ ☐ Latex (gloves, balloons)
- ☐ ☐ ☐ Aspirin
- ☐ ☐ ☐ Ibuprofen (Motrin, Advil)
- ☐ ☐ ☐ Penicillin
- ☐ ☐ ☐ Other antibiotics
- ☐ ☐ ☐ Metals (jewelry, clothing snaps)
- ☐ ☐ ☐ Acrylics
- ☐ ☐ ☐ Plant pollens
- ☐ ☐ ☐ Animals
- ☐ ☐ ☐ Foods
- ☐ ☐ ☐ Other substances _____

How often does your child brush? _____

Floss? _____

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? _____

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 OR CHANGES

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 _____

PATIENT AUTHORIZATION FOR SPECIFIC DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned, hereby authorize Quad City Orthodontics to disclose certain protected health information about me to:

_____

(Name) (Address)

Quad City Orthodontics is hereby authorized to disclose the following protected health information (specifically describe the information to be disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

☐ All Medical Records ☐ x-Rays ☐ Specific Information Listed Below:

_____

_____

_____

I understand that this request does not apply to: (1) certain health information that is not held in Quad City Orthodontics' medical records; (2) psychotherapy notes; (3) information compiled in reasonable anticipation of or for litigation; and (4) other health information not subject to the right of access under HIPAA.

The information may be disclosed for the following purpose(s):

_____

_____

This authorization will expire 90 days after the date of its execution or on _____ (name specific date or event), unless expressly revoked by me at an earlier time.

My signature below acknowledges that I understand that:

- I have the right to inspect or obtain a copy of the information to be disclosed.
- This request does not apply to certain health information that is not held in Quad City Orthodontics' medical records.
- This request does not apply to information or records compiled in reasonable anticipation of litigation.
- This request does not apply to any other health information not subject to the right of access under HIPAA.
- I may refuse to sign or, at any time, may revoke this Authorization for any reason. I understand that if I revoke this authorization, I must do so by sending a written notice of revocation to _____, and that such refusal or revocation will not affect the commencement, continuation, or quality of my treatment. I understand that the revocation will not apply to information that has already been released in response to this authorization. This Authorization will remain in effect until the term of

this Authorization specified herein expires or I provide a written notice of revocation for this Authorization.

- I understand that Quad City Orthodontics may not condition my treatment on whether I sign this authorization.
- I understand that if my protected health information is disclosed to someone who is not required to comply with the federal HIPAA regulations, then such information may be re-disclosed by the recipient and may no longer be protected by HIPAA.

I authorize the disclosure described herein. I have read and understand this authorization. I am the patient listed on this authorization or am authorized to act on behalf of the patient as the patient's personal representative. **I hereby release Quad City Orthodontics profrom all legal responsibility of liability that may arise from the act I have authorized above.** I understand copying fees may apply and agree to pay such cost on receipt.

ATTENTION: Once the above information has been released pursuant to this Authorization, it may no longer be protected by Federal and/or State laws or regulations; and may no longer be deemed "Confidential".

Signature of Patient or Legal Guardian: _____ Date: _____

Patient Name: _____ SS# _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ Phone: _____

Printed Name of Patient or Legal Guardian: _____

Witness: _____

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION

Quad City Orthodontics

Pediatric Sleep Questionnaire

Patient Name:_____

Date of Birth:_____ **Date of appointment:**_____

	Yes	No	Unsure
While sleeping does your child...			
Snore more than half the time?			
Always snore?			
Snore loudly?			
Have "heavy" or loud breathing?			
Have trouble breathing or struggle to breathe?			
Have you ever...			
Seen your child stop breathing during the night?			
Does your child...			
Tend to breathe through the mouth during the day?			
Have a dry mouth on waking up in the morning?			
Occasionally wet the bed?			
Wake up feeling un-refreshed in the morning?			
Have a problem with sleepiness during the day?			
Has a teacher or other supervisor commented that your child appears sleepy during the day?			
Is it hard to wake your child up in the morning?			
Does your child wake up with headaches in the morning?			
Did your child stop growing at a normal rate at any time since birth?			
Is your child overweight?			
This child often...			
Does not seem to listen when spoken to directly			
Has difficulty organizing tasks			
Is easily distracted by extraneous stimuli			
Fidgets with hands or feet or squirms in seat			
Is "on the go" or acts if "driven by a motor"			
Interrupts or intrudes on others (e.g. butts into conversations or games)			

Total Number of "Yes" Responses _____

If eight or more statements are answered "yes", consider referring for sleep evaluation

The American Dental Association recommends a pediatric sleep screening on ALL patients upon first visit