CONFIDENTIAL

Medical Dental History Form For Patients 17 and Younger

PATIENT

Today's Date _____ **Patient's** Cell phone #(if n/a write n/a) _____ Birth Date_____

Patient's First name _____ Middle Initial_____ Last Name_____

Prefers to be called _____ Hobbies, activities _____

What sex was the patient assigned on their birth certificate?(circle one) **Male** **Female**

What is the patient's current gender identification?(circle one) **Male** **Female** **Other**

Does the patient have any preferred pronouns? _____ How did you hear about us?_____

School _____ Grade_____

Home address _____ City, State, Zip code _____

PARENT/GUARDIAN

Custodial parent(s) name(s) _____

Patient lives with (circle 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 _____ D.O.B._____ Marital Status:_____

Employer:_____ Occupation_____

E-mail_____ Home Address *(if different)*_____

Cell phone _____ (use cell for SMS reminders?) **Y** **N** Work phone _____

Parent 2/Guardian full name _____ D.O.B._____ Marital Status:_____

Employeer_____ Occupation_____

E-mail _____ Home Address *(if different)* _____

Cell phone _____ (use cell for SMS reminders?) **Y** **N** Work phone _____

FINANCIAL RESPONSIBILITY

List ALL financial responsible parties for this account:_____

Who is primarily financially responsible for this account? _____ D.O.B._____

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

Cell phone(if different) _____ E-mail (if different) _____

Social Security #_____ Employer _____

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

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DENTAL INSURANCE

Primary policy holder's full legal name _____ Birth date _____

Social Security #_____ Relationship to patient_____

Policy Holder Address and phone *(if not listed above)* _____

Employer_____Employer Address _____

Insurance company_____Insurance Address_____

Insurance Company Phone_____Group # _____ ID# _____

Does this policy have orthodontic benefits? (circle one) Yes No Don't Know

Secondary policy holder's Full name _____ Birth date _____

Social Security #_____ Relationship to patient_____

Policy Holder Address and phone *(if not listed above)* _____

Employer_____Employer Address _____

Insurance company_____Insurace Address_____

Insurance Company Phone_____Group # _____ ID# _____

Does this policy have orthodontic benefits? (circle one) **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. _____

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PATIENT HEALTH INFORMATION

Does the patient take antibiotic pre-medication before any dental procedures?(circle one) **Y N** If Yes list:_____

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 or smoked any substance or vaped?(circle one) **Y N** if Yes list:_____

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

Any other physical problems or is the patient currently pregnant? (circle one) **Y N** If Yes list: _____

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, mark Yes, No, or don't know/understand (DK/U).

Now or in the past, has your child had:

Yes No DK/U (circle one)

Y N DK/U Frequent habit of lip sucking?

Lip Sucking: Current ____ No _____ Age stopped _____

Y N DK/U Teeth causing irritation to lip, cheek or gums?

Y N DK/U Any serious trouble associated with previous dental treatment?

If Yes please explain:

_____

_____

_____

Y N DK/U Frequent Oral Habits (sucking finger, chewing pen, etc)?

Oral Habits: Current ___ No____ Age stopped _____

Y N DK/U Frequent habit of Tongue Thrust?

Tongue Thrust: Current ___ No ___ Age stopped _____

Y N DK/U Any serious trouble associated with previous dental treatment?

Y N DK/U Has your child ever been diagnosed with gum disease or pyorrhea?

Y N DK/U Has your child been treated for "TMJ" or "TMD" problems?

Y N DK/U Clicking, locking in jaw joints?

Y N DK/U Soreness in jaw muscles or face muscles?

Y N DK/U Tooth grinding or clenching?

Grinding or Clenching: Current ___ No ___ Age stopped _____

Y N DK/U Frequent habit of nail biting?

Nail biting: Current _____ No ____ Age Stopped_____

Yes No DK/U (circle One)

Y N DK/U Erupting teeth very early or very late?

Y N DK/U Primary (baby) teeth removed that were not loose?

Y N DK/U Permanent or extra (supernumerary) teeth removed?

Y N DK/U Supernumerary (extra) or congenitally missing teeth?

Y N DK/U Chipped or injured primary or permanent teeth?

Y N DK/U Any sensitive or sore teeth?

Y N DK/U Any lost or broken fillings?

Y N DK/U Jaw fractures, cysts, infections?

Y N DK/U Any teeth treated with root canals or pulpotomies?

Y N DK/U Frequent canker sores or cold sores?

Y N DK/U History of Speech Problems or speech therapy?

Speech Therapy: Current ____ Age stopped_____

Y N DK/U Difficulty breathing through nose?

Y N DK/U Mouth breathing habit or snoring at night?

How often does your child brush? _____

How often does your child Floss?_____

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MEDICAL HISTORY

Now or in the past, has your child had:

Yes No DK/U (circle one)

Y N DK/U Emotional, sensory or developmental issues?

If Yes list:_____

Y N DK/U Hereditary or developmental conditions?

If Yes list:_____

Y N DK/U Bone fractures or major injuries?

Y N DK/U Any injuries to face, head, neck?

Y N DK/U Arthritis or joint problems?

Y N DK/U Cancer, tumor, radiation treatment or chemotherapy?

If Yes what age?:_____

Y N DK/U Endocrine or thyroid problems?

Y N DK/U Diabetes or low sugar?

If Yes list specific diagnosis:_____

Y N DK/U Kidney problems?

Y N DK/U Immune system problems?

Y N DK/U History of osteoporosis?

Y N DK/U Chest pain, shortness of breath, tire easily, swollen ankles?

Y N DK/U Heart defects, heart murmur, rheumatic heart disease?

Y N DK/U Angina, arteriosclerosis, stroke or heart attack?

Y N DK/U Does your child eat a well-balanced diet?

Y N DK/U Vision, hearing, or speech problems?

Y N DK/U Frequent ear infections, colds, throat infections?

Y N DK/U Asthma, sinus problems, hayfever?

Y N DK/U Tonsil or adenoid condition?

Y N DK/U Does your child frequently breathe through his/her mouth?

Y N DK/U Has your child ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate)?

Y N 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)?

YES No DK/U (circle one)

Y N DK/U Gonorrhea, syphilis, herpes, sexually transmitted diseases?

Y N DK/U AIDS or HIV positive?

Y N DK/U Hepatitis, jaundice, or other liver problems?

Y N DK/U Seizures, fainting spells, neurologic problems?

Y N DK/U Mental health disturbance or depression?

Y N DK/U History of eating disorder (anorexia, bulimia)?

Y N DK/U Frequent headaches or migraines

Y N DK/U High or low blood pressure?

Y N DK/U Excessive bleeding or bruising, anemia?

Y N DK/U Polio, mononucleosis, tuberculosis, pneumonia?

Y N DK/U Seizures, fainting spells, neurologic problems?

Y N DK/U Skin disorder (other than common acne)

Any additional Health related issues or more details about current issues you would like to explain further? (ie: but not limited to, undergoing evaluation for autism, ashbergers) Any special needs we need to be aware of while treating your child?

_____

_____

_____

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

Yes No DK/U (circle one)

Y N DK/U Local anesthetics (novocaine, lidocaine, xylocaine)

Y N DK/U Latex (gloves, balloons)

Y N DK/U Aspirin

Y N DK/U Ibuprofen (Motrin, Advil)

Y N DK/U Penicillin

Y N DK/U Other antibiotics

Y N DK/U Metals (jewelry, clothing snaps)

Y N DK/U Acrylics

Y N DK/U Plant pollens

Y N DK/U Animals

Y N DK/U Foods

If Yes what foods?:_____

Other substances _____ _____

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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 _____

Bellow to be updated with office personnel, if needed, at follow-up visits before treatment starts

MEDICAL HISTORY UPDATES OR CHANGES *to be completed reviewed with office personnel at observation appts.*

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 _____

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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

PATIENT AUTHORIZATION FOR SPECIFIC DISCLOSURE OF PROTECTED HEALTH INFORMATION 17 AND YOUNGER

QUAD CITY ORTHODONTICS

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

Quad City Orthodontics, LLC is hereby authorized to disclose the following protected health information deemed necessary to provide comprehensive orthodontic diagnosis or treatment. Such as:

- All Medical Records
- X-Rays
- Treatment Recommendations

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 to collaborate with auxiliary health care providers in order to provide comprehensive treatment.

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, LLC's 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 Quad City Orthodontics, LLC, 2850 24th Street Rock Island, IL 61201, 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, LLC 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, LLC, from 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". I consent that an image of my family, who enters the office, may be included in a photo for marketing purposes, names and/or other confidential details will not be shared on any marketing material without formal verbal and a separate written consent.

Signature of Legal Guardian:_____Date:_____

Patient Name:_____ SS#_____

Address:_____ City:_____State:_____ Zip:_____

DOB:_____ Phone:_____

Printed Name of Legal Guardian:_____

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