CONFIDENTIAL

Medical Dental History Form For Patients Under Age 18

PATIENT

Date ______________________

Patient's last name ______________________ First Name ______________________

Prefers to be called ______________________ Hobbies, activities ______________________

Birth date ______________________ What sex was the patient assigned at birth? ☐ Male ☐ Female

Social Security # ______________________

School ______________________ Grade ____________ Email 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

☐ Other, if other, what is the relationship?

Parent 1/Guardian full name ______________________

Occupation ______________________ Email address ______________________

Address *(if different)* ______________________

Cell phone *(if different)* ______________________ Work phone ______________________

Work phone ______________________

Parent 2/Guardian full name ______________________

Occupation ______________________ Email address ______________________

Address *(if different)* ______________________

Cell phone *(if different)* ______________________ Work phone ______________________

Work phone ______________________

Who will be responsible for picking up/dropping off patient? ______________________

DENTIST

Patient's Dentist ______________________ Address, City, State ______________________

Last seen ______________________ Reason ______________________ Next appointment ____________

Other dentist/dental specialists being seen ______________________ City, State ______________________

Reason ______________________

GENERAL INFOMATION

What concerns you about your child's teeth? ______________________

What concerns your child about their teeth? ______________________

How does your child feel about orthodontic treatment? ______________________

Why did you select our office? ______________________

Describe any previous orthodontic treatment or consultations ______________________

Does your child play any musical instruments? ______________________

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 ______________________

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? ______________________

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

Cell phone ____________ Email address(es) ____________

Social Security # ____________ Employer ____________

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

PATIENT HEALTH INFORMATION

Do you think that any of your child's activities affect 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 ____________

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

Any other physical problems? ______________________

MEDICAL HISTORY

Now or in the past, has you child had:

Yes No DK/U

☐ ☐ ☐ Emotional, sensory or developmental issues?
☐ ☐ ☐ Hereditary or developmental conditions?
☐ ☐ ☐ Bone fractures or major injuries?
☐ ☐ ☐ Any injuries to the face, head, neck?
☐ ☐ ☐ Arthritis or joint problems?
☐ ☐ ☐ High or low blood pressure?
☐ ☐ ☐ Endocrine or thyroid problems?
☐ ☐ ☐ Diabetes or low sugar?
☐ ☐ ☐ Kidney problems?
☐ ☐ ☐ Immune system problems?
☐ ☐ ☐ History of osteoporosis?
☐ ☐ ☐ Gonorrhea, syphilis, herpes, STDs?
☐ ☐ ☐ AIDS or HIV positive?
☐ ☐ ☐ Hepatitis, jaundice, or other liver problems?
☐ ☐ ☐ Polio, mononucleosis, tuberculosis, pneumonia?
☐ ☐ ☐ Seizures, fainting spells, neurological problems?
☐ ☐ ☐ Mental health disturbance or depression?
☐ ☐ ☐ History of eating disorder?
☐ ☐ ☐ Frequent oral habits (sucking finger, etc)?
Current ______ Age stopped __________
☐ ☐ ☐ Frequent habit of tongue thrust?
Current ______ Age stopped __________
☐ ☐ ☐ Frequent habit of fingernail biting?
Current ______ Age stopped __________
☐ ☐ ☐ Frequent habit of lip sucking?
Current ______ Age stopped __________
☐ ☐ ☐ Teeth causing irritation to lip, cheeks, 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?
☐ ☐ ☐ Any serious trouble associated with previous dental treatment?
☐ ☐ ☐ Has your child ever been diagnosed with gum disease or pyorrhea?

Yes No DK/U

☐ ☐ ☐ Chipped or injured primary or permanent teeth?
☐ ☐ ☐ Erupting teeth very early or very late?
☐ ☐ ☐ Primary (baby) teeth removed that were not loose?
☐ ☐ ☐ Permanent or extra teeth removed?
☐ ☐ ☐ Supernumerary(extra) or congenitally missing teeth?
☐ ☐ ☐ Any lost or broken fillings?
☐ ☐ ☐ Jaw fractures, cysts, infections?
☐ ☐ ☐ Any teeth treated with root canas 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?
☐ ☐ ☐ Frequent headaches or migraines?
☐ ☐ ☐ Any sensitive or sore teeth?
☐ ☐ ☐ Cancer, tumor, radiation treatment, chemotherapy?
☐ ☐ ☐ Excessive bleeding or bruising, anemia?
☐ ☐ ☐ 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?
☐ ☐ ☐ Angina, arteriosclerosis, stroke, or heart attack?
☐ ☐ ☐ Does your child frequently breath through their mouth?
☐ ☐ ☐ Chest pain, shortness of breath, tire easily, swollen ankles?
☐ ☐ ☐ Has your child taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate)?
☐ ☐ ☐ Has your child ever taken oral medication for bone disorders or cancer such as bisphosphonates such as Fosamax (alendronate), Skelid (tiludronate) Actonel (ridendronate), Boniva (ibandronate), or Didronal (etidronate)?

MEDICAL HISTORY continued

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

Yes No DK/U

☐ ☐ ☐ Local anesthetics (novocaine, lidocaine)
☐ ☐ ☐ Latex (gloves, balloons)
☐ ☐ ☐ Aspirin
☐ ☐ ☐ Ibuprofen (Motrin, Advil)
☐ ☐ ☐ Penicillin
☐ ☐ ☐ Other antibiotics

Yes No DK/U

☐ ☐ ☐ Metals (jewelry, clothing snaps)
☐ ☐ ☐ Acrylics
☐ ☐ ☐ Plant pollens
☐ ☐ ☐ Animals
☐ ☐ ☐ Foods
☐ ☐ ☐ Other substances ______________________

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.

Parent/Guardian signature ______________________________ Date ________________

I have read the above questions and understand them. I will not hold my orthodontist or any member of their 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 ________________

Quality of Life Survey

Evaluation of Sleep-Disordered Breathing

For each question below, please circle the number that best describes how often each symptom or problem has occurred during the past 4 weeks (or since the last survey if sooner).

	none of the time	hardly any of the time	a little of the time	some of the time	a good bit of the time	most of the time	all of the time
Sleep Disturbances							
During the past 4 weeks, how often has your child had....							
... loud snoring	1	2	3	4	5	6	7
... breath holding spells or pauses in breathing at night?	1	2	3	4	5	6	7
... choking or gasping sounds while asleep?	1	2	3	4	5	6	7
... restless sleep or frequent awakening from sleep?	1	2	3	4	5	6	7
Physical Suffering							
During the past 4 weeks, how often has your child had....							
... mouth breathing because of nasal obstruction?	1	2	3	4	5	6	7
... frequent colds or upper respiratory infections?	1	2	3	4	5	6	7
... nasal discharge or runny nose?	1	2	3	4	5	6	7
... difficulty in swallowing foods?	1	2	3	4	5	6	7
Emotional Distress							
During the past 4 weeks, how often has your child had....							
... mood swings or temper tantrums?	1	2	3	4	5	6	7
... aggressive or hyperactive behavior?	1	2	3	4	5	6	7
... discipline problems?	1	2	3	4	5	6	7
Daytime Problems							
During the past 4 weeks, how often has your child had....							
... excessive drowsiness or sleepiness?	1	2	3	4	5	6	7
... poor attention span or concentration?	1	2	3	4	5	6	7
... difficulty getting out of bed in the morning?	1	2	3	4	5	6	7
Caregiver Concerns							
During the past 4 weeks, how often have the above problems...							
... caused you to worry about your child's general health?	1	2	3	4	5	6	7
... created concern that your child is not getting enough air?	1	2	3	4	5	6	7
... interfered with your ability to perform daily activities?	1	2	3	4	5	6	7
... made you frusterated?	1	2	3	4	5	6	7

Overall, how would you rate your child's quality of life as a result of the above problems?

0 1 2 3 4 5 6 7 8 9 10

Pediatric Sleep Questionnaire

Patient's Name:____ Date: _____________

While sleeping, does your child...	Yes	No	Don't Know
Snore more than half the time?			
Always snore?			
Snore loudly?			
Have heavy or loud breathing?			
Have trouble breathing/struggle to breathe?			
Have you ever...			
Seen your child stop breathing during sleep?			
Does your child...			
Tend to breathe through their mouth while awake?			
Have a dry mouth upon 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 supervisor commented that your child appears to sleep during the day?			
Is it hard to wake your child in the morning?			
Does your child wake up with headaches?			
Did your chuld stop growing at a normal rate at any time since birth?			
Is your child overweight?			
My child often...			
Does not seem to listen when spoken to directly.			
Has difficulty organizing tasks.			
Is easily distracted by extraneous stimuli.			
Fidgets with hands/feet or squirms in seat.			
Is always "on the go" or often acts as if "driven by a motor."			
Frequently interrupts or intrudes on others (e.g. butts into conversations or games).			

Total number of 'Yes' responses: ________________________

If eight or more statements are answered with 'Yes,' consider referring for sleep evaluation.

Patient Consent Form

L. Douglas Knight, DMD, ABO

I understand, that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third-party payers.

- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:______________________________ Date: ____________
(Please Print)

Parent/Guardian Signature: ______________________________________