



American Association of Orthodontists

CONFIDENTIAL

Medical Dental History Form for Patients Under Age 18

PATIENT

Date
Patient's last name
First name
Middle initial
Prefers to be called
Hobbies, activities
Birth date
Sex
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
Father's full name
Title
Occupation
Email address
Address
Home phone
Cell phone
Work phone
Mother's full name
Title
Occupation
Email address
Address
Home Phone
Cell phone
Work phone

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 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?

## CONFIDENTIAL HEALTH HISTORY

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?  
If NO, explain: \_\_\_\_\_
2. Yes / No Has there been a change in your health within the last year?  
If YES, explain: \_\_\_\_\_
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?  
If YES, explain: \_\_\_\_\_
4. Yes / No Are you being treated by a physician now? If YES, explain: \_\_\_\_\_  
Date of last medical exam? \_\_\_\_\_ Reason for exam: \_\_\_\_\_
5. Yes / No Have you had problems with prior dental treatment?  
If YES, explain: \_\_\_\_\_  
Date of last dental exam: \_\_\_\_\_ Name of last treating dentist: \_\_\_\_\_
6. Yes / No Are you in pain now?  
If YES, explain: \_\_\_\_\_

### II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

- |   |                                   |                                  |
|---|-----------------------------------|----------------------------------|
| Yes / No Chest pain (angina)            | Yes / No Blood in stools          | Yes / No Frequent vomiting       |
| Yes / No Fainting spells                | Yes / No Diarrhea or constipation | Yes / No Jaundice                |
| Yes / No Recent significant weight loss | Yes / No Frequent urination       | Yes / No Dry mouth               |
| Yes / No Fever                          | Yes / No Difficulty urinating     | Yes / No Excessive thirst        |
| Yes / No Night sweats                   | Yes / No Ringing in ears          | Yes / No Difficulty swallowing   |
| Yes / No Persistent cough               | Yes / No Headaches                | Yes / No Swollen ankles          |
| Yes / No Coughing up blood              | Yes / No Dizziness                | Yes / No Joint pain or stiffness |
| Yes / No Bleeding problems              | Yes / No Blurred vision           | Yes / No Shortness of breath     |
| Yes / No Blood in urine                 | Yes / No Bruise easily            | Yes / No Sinus problems          |
- Other: \_\_\_\_\_

### III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

- |  |  |                                     |
|--|--|-------------------------------------|
| Yes / No Heart disease                   | Yes / No AIDS/HIV                        | Yes / No Psychiatric care           |
| Yes / No Family history of heart disease | Yes / No Surgeries                       | Yes / No Osteoporosis               |
| Yes / No Heart attack                    | Yes / No Hospitalization                 | Yes / No Thyroid disease            |
| Yes / No Artificial joint                | Yes / No Diabetes                        | Yes / No Asthma                     |
| Yes / No Stomach problems or ulcers      | Yes / No Family history of diabetes      | Yes / No Hepatitis                  |
| Yes / No Heart defects                   | Yes / No Tumors or cancer                | Yes / No Sexual transmitted disease |
|  | Yes / No Sleep Apnea                     |                                     |
| Yes / No Heart murmurs                   | Yes / No Chemotherapy                    | Yes / No Herpes                     |
| Yes / No Rheumatic fever                 | Yes / No Radiation                       | Yes / No Canker or cold sores       |
| Yes / No Skin disease                    | Yes / No Arthritis, rheumatism           | Yes / No Anemia                     |
| Yes / No Hardening of arteries           | Yes / No Emphysema or other lung disease | Yes / No Liver disease              |
| Yes / No High blood pressure             | Yes / No Kidney or bladder disease       | Yes / No Eye disease                |
| Yes / No Seizures                        | Yes / No Stroke                          | Yes / No Transplants                |
| Yes / No Cosmetic surgery                | Yes / No Eating disorders                | Yes / No Tuberculosis               |
- Other: \_\_\_\_\_

**IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?** (Please circle Yes or No for each)

Yes / No Aspirin	Yes / No Valium or sedatives	Yes / No Codeine or other opioids
Yes / No Penicillin or other antibiotics	Yes / No Latex	Yes / No Food
Yes / No Nitrous oxide	Yes / No	Local anesthetic
Yes / No Metal		

Others: \_\_\_\_\_

**V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?** (Please circle Yes or No for each)

Yes / No Recreational drugs	Yes / No Tobacco in any form	Yes / No Antibiotics
Yes / No Over-the-counter medicines	Yes / No Alcohol	Yes / No Supplements
Yes / No Weight loss medications	Yes / No Bisphosphonate (Fosamax)	Yes / No Aspirin
Yes / No Anti-Depressants	Yes / No Herbal supplements	
Yes / No Opioids (e.g., Norco, Vicodin, Percocet, Percodan)	If YES, please explain reason: _____	

Please list all prescription medications: \_\_\_\_\_

**VI. WOMEN ONLY** (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month? \_\_\_\_\_

Yes / No Are you nursing? \_\_\_\_\_

Yes / No Are you taking birth control pills? \_\_\_\_\_

**VII. ALL PATIENTS** (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?  
If YES, please explain: \_\_\_\_\_

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: \_\_\_\_\_

Yes / No Have you ever taken Fen-Phen? If YES, when: \_\_\_\_\_

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

*The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.*

I authorize the dentist to contact my physician.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Whom would you like us to contact in case of an emergency?:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.**

\_\_\_\_\_  
Signature of Patient (Parent or Guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Dentist

\_\_\_\_\_  
Date





We would like to welcome you to our office. In an effort to assist you in receiving the greatest benefit from your orthodontic insurance, we ask you to fill out this form as completely as possible. Thank you for your cooperation.



Date .....

**PATIENT'S PRIMARY INSURANCE INFORMATION**

Patient's Name ..... Birth Date ..... Relationship to Insured .....

Insured Name ..... Birth Date ..... Social Security Number .....

Employer .....

Employer's Address .....

Insurance Co. Name ..... Policy or Group No. ....

Insurance Co. Address .....

Insurance Co. Telephone (800 No. if available) .....

**PLEASE COMPLETE THE FOLLOWING INFORMATION IF THE PATIENT IS COVERED BY A SECOND INSURANCE POLICY.**

**PATIENT'S SECONDARY INSURANCE INFORMATION**

Insured Name ..... Birth Date ..... Social Security Number .....

Patient Relationship to the Insured .....

Employer .....

Employer's Address .....

Insurance Co. Name ..... Policy or Group No. ....

Insurance Co. Address .....

Insurance Co. Telephone (800 No. if available) .....

**RELEASE AND ASSIGNMENT**

Patient's Name .....

**I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATIONS RENDERED, TO MY INSURANCE COMPANY OR COMPANIES.**

**THIS RELEASE IS SOLELY FOR THE PURPOSE OF FACILITATING THE BILLING AND REIMBURSEMENT DIRECTLY TO THE DOCTOR, OF INSURANCE BENEFITS UNDER WHICH I AM ENTITLED.**

Signature ..... Print your Name .....

Signature ..... Print your Name .....



## PRIVACY NOTICE

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.);
- To third party payors or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- To your family and close friends involved in your treatment; and/or,
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

### **Under the new privacy rules, you have the right to:**

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

### **We have the following duties under the privacy rules:**

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect; and,
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.



**Please note that we are not obligated to:**

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

**PATIENT ACKNOWLEDGMENT**

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date