Member American Association of Orthodontists®
My Life. My Smile. My Orthodontist.®

HOLMAN ORTHODONTICS
Bracing for the Future.

Date: _____

MEDICAL/DENTAL HISTORY FORM FOR PATIENTS UNDER 18

PATIENT INFORMATION

Patient's Name: _____ I Prefer to be Called: _____ DOB: ___/___/___ Age: _____ Sex: M/F

Patient's Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone No.: _____ Attends School At: _____ Grade: _____

Sports And/Or Hobbies: _____ Other family members treated here: _____

Who suggested that your child might need orthodontic treatment? _____

How did you first learn about our office: _____

RESPONSIBLE PARTY INFORMATION

Mother/Guardian's Name: _____ DOB: _____ SS #: _____

Address (if different than patient's): _____ City: _____ State: _____ Zip Code: _____

Work No: _____ Cell No: _____ Phone Carrier: _____

Father/Guardian's Name: _____ DOB: _____ SS #: _____

Address (if different than patient's): _____ City: _____ State: _____ Zip Code: _____

Work No: _____ Cell No: _____ Carrier: _____

E-mail address: _____

Please circle how you like to receive appointment reminders. You may choose multiple: **Email** **Text Message** **Phone Call**

Name of Patient's Dentist: _____ Date Last Seen: _____ Reason: _____

Name of Patient's Physician: _____ Date Last Seen: _____ Reason: _____

DENTAL INSURANCE INFORMATION

Primary Policy Holder's Name: _____ SS#: _____ ID#: _____ DOB: ___/___/___

Insurance Company: _____ Phone No: _____

Insurance Company Address: _____

Secondary Policy Holder's Name: _____ SS#: _____ ID#: _____ DOB: ___/___/___

Insurance Company: _____ Phone No: _____

Insurance Company Address: _____

DENTAL HISTORY Now or in the past, has the patient had:

☐yes ☐no Started teething very early or late?
☐yes ☐no Any teeth removed for any reason?
☐yes ☐no Supernumerary (extra) or congenitally missing teeth?
☐yes ☐no Chipped or otherwise injured primary (baby) or permanent teeth?
☐yes ☐no Teeth sensitive to hot or cold; teeth throb or ache?
☐yes ☐no Jaw fractures, cysts or mouth infections?
☐yes ☐no "Dead teeth" or root canals treated?
☐yes ☐no Periodontal problems, bleeding gums, bad taste or mouth odor?
☐yes ☐no Thumb, finger, or sucking habit? Until what age _____?
☐yes ☐no Abnormal swallowing habit (tongue thrusting)?
☐yes ☐no History of speech problems?
☐yes ☐no Mouth breathing habit, snoring or difficulty in breathing?

☐yes ☐no Tooth grinding, jaw clenching clicking or locking?
☐yes ☐no Any pain in jaw or ringing in the ears?
☐yes ☐no Difficulty encountered in chewing or jaw opening?
☐yes ☐no Aware of loose, broken or missing restorations (fillings)?
☐yes ☐no Any teeth irritating cheek, lip, tongue or palate?
☐yes ☐no Frequent canker sores or cold sores?
☐yes ☐no Taking any forms of fluoride?
☐yes ☐no Is patient sensitive or self-conscious about teeth?
☐yes ☐no Ever had a prior orthodontic examination or treatment?

How does patient feel about braces? _____

What concerns you most about his/her teeth? _____

MEDICAL HISTORY Now or in the past, has the patient had:

☐yes ☐no	Birth defects or hereditary problems?
☐yes ☐no	Bone fractures, any major accidents?
☐yes ☐no	Rheumatoid or arthritic conditions?
☐yes ☐no	Endocrine or thyroid problems?
☐yes ☐no	Kidney problems?
☐yes ☐no	Diabetes?
☐yes ☐no	Cancer, tumor, radiation treatment or chemotherapy?
☐yes ☐no	Stomach ulcer or hyperacidity?
☐yes ☐no	Polio, mononucleosis, tuberculosis or pneumonia?
☐yes ☐no	Problems of the immune system? AIDS or HIV positive?
☐yes ☐no	Hepatitis, jaundice or liver problem?
☐yes ☐no	Fainting spells, seizures, epilepsy or neurological problem?
☐yes ☐no	Mental health disturbance or behavioral problem?
☐yes ☐no	Vision, hearing, tasting or speech difficulties?
☐yes ☐no	Loss of weight recently, poor appetite?
☐yes ☐no	History of eating disorder (anorexia, bulimia)?
☐yes ☐no	Excessive bleeding or bruising tendency, anemia or bleeding disorder?
☐yes ☐no	High or low blood pressure?
☐yes ☐no	Chest pain, shortness of breath or swelling ankles?
☐yes ☐no	Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
☐yes ☐no	Skin disorder?
☐yes ☐no	Does the patient eat a well-balanced diet?
☐yes ☐no	Frequent headaches, colds or sore throats?
☐yes ☐no	Eye, ear, nose or throat condition?
☐yes ☐no	Hayfever, asthma, sinus trouble or hives?
☐yes ☐no	Tonsil or adenoid conditions?

Circle allergies or reactions to any of the following:

Local anesthetics (Novocaine)	Codeine or other narcotics
Aspirin	Ibuprofen (Motrin, Advil)
Penicillin or other antibiotics	Sulfa drugs
Metals (jewelry)	Latex (gloves, balloons)
Vinyl, Acrylic, or Animals	Foods (specify)

Please list any medication, nutrient supplements, herbal medications or non prescription medicine being taken by the patient.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

☐yes ☐no	Current or past substance abuse problem?
☐yes ☐no	Does the patient chew or smoke tobacco?
☐yes ☐no	Operations or Surgery? Describe: _____
☐yes ☐no	Hospitalized? For: _____
☐yes ☐no	Being treated by another health care professional? For: _____

Are there any other medical conditions that we should be aware of?

GIRLS ONLY

☐yes ☐no	Has the patient started her monthly periods? If so, approximately when was her initial one? _____
☐yes ☐no	Is the patient pregnant?

FAMILY MEDICAL HISTORY

List any family medical conditions that we should know about?

How often does your child brush? _____ Floss? _____

I have read and understand the above questions. 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. If there are any changes later to this history record or medical/dental status, I will so inform this practice. Further more, I consent to an orthodontic examination and, if necessary, orthodontic records which include photos, impressions for study models, and two radiographs.

Signed: _____ Date Signed: _____
(Parent or Guardian)

Signed: _____ Date Signed: _____
(Dental Staff Member)

Holman Orthodontics

Dr. Brian Holman D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please Print Name of Responsible Party

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, But acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)