hickman orthodontics

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DENTAL HISTORY

Frequency of dental checkup? _____ Date of last visit? _____

How many times per day does patient brush? _____

Does patient floss daily? ☐ No ☐ Yes

Does patient receive topical fluoride? ☐ No ☐ Yes

Is there any unfinished dental care to be completed? ☐ No ☐ Yes Explain _____

Is patient frightened about dental treatment? ☐ No ☐ Yes Explain _____

Has patient had an unpleasant experience in a dental office? ☐ No ☐ Yes Explain _____

Does patient play any musical instrument? ☐ No ☐ Yes What type? _____

Has patient consulted an orthodontist previously? ☐ No ☐ Yes With whom? _____

Has patient undergone any prior orthodontic treatment? ☐ No ☐ Yes By whom? _____

Were you satisfied with the prior treatment? ☐ No ☐ Yes Explain _____

Have any other family members had a similar dental pattern? ☐ No ☐ Yes Who? _____

Was it treated? ☐ No ☐ Yes By whom? _____

Has patient ever sustained any injury to mouth, teeth, jaws, ☐ No ☐ Yes Explain _____
neck or head? _____

Has patient ever had muscular soreness around head/neck? ☐ No ☐ Yes

Problems with bleeding gums? ☐ No ☐ Yes

Oral surgery procedure? ☐ No ☐ Yes Periodontal (gum) treatment? ☐ No ☐ Yes

Prosthodontic (crown & bridge) treatment? ☐ No ☐ Yes Endodontic (root canal) treatment? ☐ No ☐ Yes

Does the patient have difficulty in swallowing/chewing food? ☐ No ☐ Yes Explain _____

Is the patient self-conscious about wearing braces? ☐ No ☐ Yes Explain _____

What are the patient's chief concerns regarding his/her teeth? _____

What are the parent's chief concerns about the patient's teeth? _____

What are the dentist's chief concerns about the patient's teeth? _____

Does the patient desire an improved dental appearance? ☐ No ☐ Yes

Does the patient clench/grid his/her teeth? ☐ No ☐ Yes When? _____

Does the patient have a nail biting habit? ☐ No ☐ Yes Lip biting habit? ☐ No ☐ Yes

Does the patient suck thumb or finger? ☐ No ☐ Yes If stopped, at what age? _____

Does the patient have a history of canker sores? ☐ No ☐ Yes

Has the patient ever had jaw joint pain? ☐ No ☐ Yes Jaw joint clicking? ☐ No ☐ Yes

Jaw joint locking? ☐ No ☐ Yes Jaw joint popping ? ☐ No ☐ Yes Jaw joint grating noises? ☐ No ☐ Yes

Since diagnostic x-rays may be indicated, in the case of a female patient, is there presently a possibility of pregnancy?
☐ No ☐ Yes

I certify that the above medical history is accurate at this time. If there are future changes, I will inform the office. I also authorize this office to examine and initiate necessary dental services for this minor patient.

Signature _____ Date _____

Treatment Coordinator/Date _____

MEDICAL HISTORY

Your answers to the following questions will be helpful in setting the safest and most effective means of providing your child's orthodontic care. All information will be kept completely confidential.

Physician's Name _____ Phone _____

Has the patient experienced any health problems? ☐ No ☐ Yes Explain _____

Any major change in the patient's health recently? ☐ No ☐ Yes Explain _____

Is the patient currently under physician's care? ☐ No ☐ Yes Explain _____

Is the patient currently taking medications? ☐ No ☐ Yes List _____

Is the patient allergic to any medications, metals, latex, plastics or other? ☐ No ☐ Yes List _____

Has the patient ever been hospitalized? ☐ No ☐ Yes When? _____

Have the patient's tonsils/adenoids been removed? ☐ No ☐ Yes When? _____

Does the patient have any physical or mental impairment? ☐ No ☐ Yes Explain _____

Has or is the patient currently undergoing speech therapy? ☐ No ☐ Yes Explain _____

Please check if patient has a history of any of the following conditions:

- ☐ Heart Murmur
- ☐ Frequent Headaches
- ☐ Rheumatic Fever
- ☐ Mitral Valve Prolapse
- ☐ Congenital Heart Disorder
- ☐ Endocrine Disorders
- ☐ Thyroid Problems
- ☐ Liver Disease
- ☐ Hay Fever
- ☐ Fainting Episodes
- ☐ Emotional Problems
- ☐ Nervous/Anxious
- ☐ Prolonged Bleeding
- ☐ Hemophilia
- ☐ Blood Disease
- ☐ Bone Disorder
- ☐ Development Disorder
- ☐ Kidney Disease
- ☐ Herpes (Fever Blisters)
- ☐ Venereal Disease
- ☐ Allergies
- ☐ HIV Positive
- ☐ Hepatitis (A)
- ☐ Hepatitis (B)
- ☐ Hepatitis (C)
- ☐ Drug Addiction
- ☐ Tonsillitis
- ☐ Heart Surgery
- ☐ Arthritis
- ☐ Diabetes
- ☐ Mouth Breather
- ☐ Growth Disorders
- ☐ Cancer
- ☐ AIDS
- ☐ Epilepsy
- ☐ Asthma
- ☐ Bronchitis
- ☐ Tuberculosis
- ☐ Hives/Rash

Are there any other conditions/problems of which we should be aware?

Comments: _____

_____

MEDICAL HISTORY UPDATE:

Date	Comments	Signature

GROWTH INFORMATIN FOR PATIENTS UNDER 16 YEARS OF AGE

Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are needed to aid our selection of treatment alternatives:

Has your son/daughter reached puberty? ☐ No ☐ Yes

Females– Has she started menstruation? ☐ No ☐ Yes When? _____

Males– Has his voice changed: ☐ No ☐ Yes When? _____ Has he begun to shave? ☐ No ☐ Yes When? _____

Height _____ Do you feel growth is complete? ☐ No ☐ Yes Explain _____

Is patient presently undergoing a rapid change in height? ☐ No ☐ Yes

Father's height _____ Mother's height _____ Is child adopted? ☐ No ☐ Yes

Names and birthdates of patient's siblings: _____