Date: _____

CONFIDENTIAL

American Association of Orthodontists
MEDICAL DENTAL HISTORY FORM FOR PATIENTS UNDER 18 YEARS OF AGE

Patient's Last Name: _____ First Name: _____ Middle Name/Initial: _____

Birth Date: _____ Age: _____ Sex: Male ☐ Female ☐ Prefers To Be Called: _____

S.S.N./S.I.N.: _____ Home Phone No.: (_____) _____-_____

Patient's Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Attends School At: _____ Grade: _____ Musical Instruments Played: _____

Sports And/Or Hobbies: _____

No. of brothers and sisters: _____ Ages: _____

Other family members treated here:_____

Birth Father's Height _____ft. _____in. Birth Mother's Height _____ft._____in.

Patient's Birth Weight _____lbs._____oz. Patient's Present Weight _____lbs. Height _____ft. _____in.

Custodial Parent(s) or Guardian(s): _____ Phone No. (if different than patient's): (_____)_____-_____

Address (if different than patient's): _____

City: _____ State/Province: ___ Zip/Postal Code: _____

E-mail address:_____ Cell phone/pager:_____

Name Of Patient's Dentist: _____ Phone No.: (_____)_____-_____

Dentist's Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Date Last Seen: _____ Reason: _____

Name Of Patient's Physician (s): _____ Phone No(s).: (_____)_____-_____

Physician's Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Date Last Seen:_____ Reason: _____

Who Is Financially Responsible For This Account? Last Name: _____ First Name: _____ Middle Name/Initial: _____

Address (if different from patient's

For the following questions mark yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

PATIENT PROFILE

☐**yes** ☐**no** ☐**dk/u** Does patient follow directions well?

☐**yes** ☐**no** ☐**dk/u** Does patient brush his/her teeth conscientiously?

☐**yes** ☐**no** ☐**dk/u** Does patient have learning disabilities or need extra help with instructions?

☐**yes** ☐**no** ☐**dk/u** Is patient sensitive or self-conscious about teeth?

MEDICAL HISTORY

Now or in the past, has the patient had:

☐**yes** ☐**no** ☐**dk/u** Birth defects or hereditary problems?

☐**yes** ☐**no** ☐**dk/u** Bone fractures, any major accidents?

☐**yes** ☐**no** ☐**dk/u** Rheumatoid or arthritic conditions?

☐**yes** ☐**no** ☐**dk/u** Endocrine or thyroid problems?

☐**yes** ☐**no** ☐**dk/u** Kidney problems?

☐**yes** ☐**no** ☐**dk/u** Diabetes?

☐**yes** ☐**no** ☐**dk/u** Cancer, tumor, radiation treatment or chemotherapy?

☐**yes** ☐**no** ☐**dk/u**

MEDICAL HISTORY UPDATE OR CHANGES

Comments: ____

Signed: ____ Date Signed: ______________
(Parent or Guardian)
Signed: ____ Date Signed ______________
(Dental Staff Member)

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