



Confidential Patient Form

Medical & Dental History

For patients under age 18

A parent or guardian should complete this form. Type into the boxes on your computer, or print it and fill it out by hand. Bring it to your appointment, or use the secure online version on our New Patients page. Questions? Call (718) 238-9888.

Keeping Your Information Private

Do not email this form, text it, or send photos of it; these are not secure for health information. On a shared or public computer, print it without saving, then delete the download. Afterward, delete any filled-in copies saved on your device.

Patient Information

Date	Social Security #	Birth date
Patient's last name	First name	Middle initial
Prefers to be called	Hobbies, activities	
What is the patient's gender?	School	Grade
☐ Male ☐ Female		
E-mail address(es)	Home phone	Cell phone
Home address	City, State, Zip code	

Parent/Guardian

Custodial parent(s) name(s)		
Patient lives with (check all that apply)		
☐ Parent 1/Guardian	☐ Parent 2/Guardian	☐ Parent 3/Guardian ☐ Parent 4/Guardian
Other. If other, what is the relationship?		
Parent 1/Guardian full name	Occupation	
E-mail address	Address (if different)	
Cell phone (if different)	Home phone	Work phone

Parent 2/Guardian full name

Occupation

E-mail address

Address (if different)

Cell phone (if different)

Home phone

Work phone

Financial Responsibility

Who is financially responsible for this account?

Employer

Address

City, State, Zip

Cell phone

Home phone

E-mail address(es)

Social Security #

Who will be responsible for bringing the patient to orthodontic appointments?

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

Physician

Patient's physician

City, State

Last seen

Reason

Next appointment

Most recent physical exam

Other physicians/health care providers being seen now:

Name

City, State

Reason

Name

City, State

Reason

Name

City, State

Reason

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/their teeth?

How does your child feel about orthodontic treatment?

Who suggested that your child might need orthodontic treatment?

Why did you select our office?

Does your child play a musical instrument?

Describe any previous orthodontic treatment or consultations.

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.

Patient Health Information

Does the patient take antibiotic pre-medication before any dental procedures?

☐ Yes ☐ No

Does the patient currently have (or ever had) a substance abuse problem?

Do you think that any of your child's activities affect his/her/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

Does your child chew or smoke tobacco?

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

Any other physical problems?

Your answers are for office records only and are confidential. A thorough medical history is essential to a complete orthodontic evaluation. For the following questions, mark yes, no, or don't know/understand (DK/U).

Dental History

Now or in the past, has your child had:

Yes No DK/U

- ☐ ☐ ☐ Erupting teeth very early or very late?
- ☐ ☐ ☐ Primary (baby) teeth removed that were not loose?
- ☐ ☐ ☐ Permanent or extra (supernumerary) teeth removed?
- ☐ ☐ ☐ Supernumerary (extra) or congenitally missing teeth?
- ☐ ☐ ☐ Chipped or injured primary or permanent teeth?
- ☐ ☐ ☐ Any sensitive or sore teeth?
- ☐ ☐ ☐ Any lost or broken fillings?
- ☐ ☐ ☐ Jaw fractures, cysts, infections?
- ☐ ☐ ☐ Any teeth treated with root canals 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?

Yes No DK/U

- ☐ ☐ ☐ History of speech problems?
- ☐ ☐ ☐ Frequent oral habits (sucking finger, chewing pen, etc.)?
- Current: ☐ Yes ☐ No Age stopped
- ☐ ☐ ☐ Frequent habit of tongue thrust?
- Current: ☐ Yes ☐ No Age stopped
- ☐ ☐ ☐ Frequent habit of fingernail biting?
- Current: ☐ Yes ☐ No Age stopped
- ☐ ☐ ☐ Frequent habit of lip sucking?
- Current: ☐ Yes ☐ No Age stopped
- ☐ ☐ ☐ Teeth causing irritation to lip, cheek or gums?
- ☐ ☐ ☐ Tooth grinding or clenching?
- ☐ ☐ ☐ Clicking, locking in jaw joints?
- ☐ ☐ ☐ Soreness in jaw muscles or face muscles?

Yes No DK/U

- ☐ ☐ ☐ Has your child been treated for "TMJ" or "TMD" problems?
- ☐ ☐ ☐ Any broken or missing fillings?

Yes No DK/U

- ☐ ☐ ☐ Any serious trouble associated with previous dental treatment?
- ☐ ☐ ☐ Has your child ever been diagnosed with gum disease or pyorrhea?

Medical History

Now or in the past, has your child had:

Yes No DK/U

- ☐ ☐ ☐ Emotional, sensory or developmental issues?
- ☐ ☐ ☐ Hereditary or developmental conditions?
- ☐ ☐ ☐ Bone fractures or major injuries?
- ☐ ☐ ☐ Any injuries to face, head, neck?
- ☐ ☐ ☐ Arthritis or joint problems?
- ☐ ☐ ☐ Cancer, tumor, radiation treatment or chemotherapy?
- ☐ ☐ ☐ Endocrine or thyroid problems?
- ☐ ☐ ☐ Diabetes or low sugar?
- ☐ ☐ ☐ Kidney problems?
- ☐ ☐ ☐ Immune system problems?
- ☐ ☐ ☐ History of osteoporosis?
- ☐ ☐ ☐ Gonorrhea, syphilis, herpes, sexually transmitted diseases?
- ☐ ☐ ☐ AIDS or HIV positive?
- ☐ ☐ ☐ Hepatitis, jaundice, or other liver problems?
- ☐ ☐ ☐ Polio, mononucleosis, tuberculosis, pneumonia?
- ☐ ☐ ☐ Seizures, fainting spells, neurologic problems?
- ☐ ☐ ☐ Mental health disturbance or depression?
- ☐ ☐ ☐ History of eating disorder (anorexia, bulimia)?
- ☐ ☐ ☐ Frequent headaches or migraines?

Yes No DK/U

- ☐ ☐ ☐ High or low blood pressure?
- ☐ ☐ ☐ Excessive bleeding or bruising, anemia?
- ☐ ☐ ☐ Chest pain, shortness of breath, tire easily, swollen ankles?
- ☐ ☐ ☐ Heart defects, heart murmur, rheumatic heart disease?
- ☐ ☐ ☐ Angina, arteriosclerosis, stroke or heart attack?
- ☐ ☐ ☐ 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?
- ☐ ☐ ☐ Does your child frequently breathe through his/her mouth?
- ☐ ☐ ☐ Has your child ever taken intravenous bisphosphonates such as Zometa (zoledronic 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), Actonel (risedronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate)?

Allergies

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

Yes No DK/U

- ☐ ☐ ☐ Local anesthetics (novocaine, lidocaine, xylocaine)
- ☐ ☐ ☐ 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 (please list)

How often does your child brush?

Floss?

Family Medical History

Have the parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders

Diabetes

Arthritis

Severe allergies

Unusual dental problems

Jaw size imbalance

Other family medical conditions?

Release and Waiver

I authorize release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company.

Parent/Guardian Signature

Date

I have read the above questions and understand them. 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. 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

For use at later visits.

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