VILLAGE ORTHODONTICS

DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

Member American Association of Orthodontists

MINNEAPOLIS ORTHODONTICS

CONFIDENTIAL MEDICAL/DENTAL HISTORY FOR MINORS

Andrew J. Wahl, DDS, PA
www.discoverbraces.com

Patient's Full Name:_____ **Prefers to be called:**_____

Date of Birth:_____ Age:_____ Gender:_____

Who is with patient at appt today:_____ Patient Resides With:_____

Names & Ages of Siblings:_____

School:_____Grade:_____Interests/Activities:_____

Have any family members been treated by Dr. Wahl _____ If so, who?_____

Whom may we thank for referring you to Village/Minneapolis Orthodontics?_____

Has the patient ever had an orthodontic exam or treatment?_____Where & When?_____

What is your primary orthodontic concern?_____

Is the patient sensitive or self-conscious about the appearance of his/her teeth or smile?_____

Successful orthodontic treatment depends greatly upon the patient's complete cooperation in following instructions, keeping appointments and maintaining excellent oral hygiene. Are there any restrictions, limitations or problems that might prevent the patient from participating fully in his/her orthodontic treatment?_____Please explain:_____

Parent Name:_____ Prefers to be called:_____ DOB: _____

(please check) ____married ____remarried ____single ____divorced ____widowed ____partner

Home Address:_____Home Phone:_____

(Street, City, State, ZIP)

Email Address:_____Cell Phone:_____Work Phone:_____

Employer:_____Occupation:_____

Parent Name:_____ Prefers to be called:_____ DOB: _____

(please check) ____married ____remarried ____single ____divorced ____widowed ____partner

Home Address:_____Home Phone:_____

(Street, City, State, ZIP)

Email Address:_____Cell Phone:_____Work Phone:_____

Employer:_____Occupation:_____

Best contact for appointment scheduling:_____Phone:_____Email:_____

Person Responsible for Account:_____

Do you have orthodontic coverage as part of your dental insurance?_____If no, skip the section below.

PRIMARY DENTAL INSURANCE

Policy Holder:_____DOB:_____

Insurance Company:_____

Insurance Co. Address:_____

Employer:_____Group#_____

ID#_____SSN_____

SECONDARY DENTAL INSURANCE

Policy Holder:_____DOB:_____

Insurance Company:_____

Insurance Co. Address:_____

Employer:_____Group#_____

ID#_____SSN_____

Dentist's or Clinic Name:_____ Last Exam/Visit:_____

Physician's Name:_____ Last Exam:_____ Is the patient generally in good health?_____

Is the patient currently being treated for any medical condition:_____

Please list all prescription and non-prescription medications or supplements the patient is taking:_____

_____

Health History: please check all that apply, now or in the past.

_____Birth defects or hereditary problems
_____Bone fractures or major accident
_____Rheumatoid arthritic condition
_____Endocrine or thyroid conditions/treatment
_____Diabetes (Type I, Type II)
_____Cancer, tumor or radiation treatment
_____Immune system condition
_____AIDS or HIV
_____Tuberculosis (active or latent/dormant)
_____Hepatitis, jaundice or liver condition
_____Fainting spells, seizures, epilepsy, neurologic problems
_____Mental health or behavioral problems or ADD/ADHD
_____History of eating disorder (anorexia or bulimia)
_____History of or current substance abuse
_____Uses tobacco (chews or smokes)
_____Bleeding or bruising tendency or anemia
_____High or low blood pressure
_____Cardiovascular problem, heart murmur, rheumatic fever
_____Frequent headaches, colds or sore throats
_____Eye, ear, nose or throat condition
_____Hayfever, asthma, sinus trouble or hives
_____Tonsil or adenoid condition or removed
_____Sleep Apnea
_____Allergic to local anesthetics (Novocaine or Lidocaine)
_____Allergic to Aspirin or Ibuprofen
_____Allergic to penicillin or other antibiotics
_____Allergic to sulfa drugs
_____Allergic to codeine or other narcotics
_____Allergic to any metals
_____Allergic to latex, vinyl or acrylic
_____Food allergies (specify)_____
_____Other allergies/reactions (specify)_____
_____Patient has reached puberty. If yes, at age:_____
Birth mother's height:_____ Birth father's height:_____

Please fully explain any medical conditions checked:_____

_____

_____

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

_____

_____

Dental History: please check all that apply, now or in the past

_____Requires premedication for dental procedures
_____Is apprehensive about dental procedures
_____Serious problem with previous dental procedure
_____Primary or "baby" tooth/teeth extracted
_____Permanent tooth/teeth extracted
_____Congenitally missing permanent tooth/teeth
_____Supernumerary or "extra" tooth/teeth
_____Chipped or injured tooth/teeth
_____Loose, broken or missing fillings
_____Root canal or endodontic treatment
_____Tooth sensitivity to hot or cold
_____Takes fluoride
_____Canker sores or cold sores
_____Periodontal "gum" problems or treatment
_____Jaw fracture, cysts or mouth infection
_____Thumb, finger or other sucking habit
Resolved?_____At age:_____
_____History of speech problems
_____Mouth breathing, snoring or breathing difficulties
_____Abnormal swallowing pattern/tongue thrust
_____Jaw joint pain, clicking/popping or locking
_____Tooth grinding or clenching
_____Pain or ringing in ears
_____Pain or soreness in face or jaw muscles
_____Difficulty chewing or opening
_____Under or over developed jaw
_____Family history of under or over-developed jaw

All of the information provided by me on this form is correct to the best of my knowledge. I will notify Village/Minneapolis Orthodontics of any changes in the patient's health status. Information disclosed on this form is considered protected health information and will not be disclosed to anyone except when necessary to carry out treatment, payment activities and healthcare information to my insurance company. I understand that a credit bureau report may be obtained if I intend to initiate treatment at Village/Minneapolis Orthodontics. I give permission for clinical examination.

Signed:_____
(parent or guardian)

Date:_____