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Board Certified Orthodontist

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Cypress
Orthodontic and Pediatric Dentistry

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MEDICAL DENTAL HISTORY FORM CHILD PATIENT INFORMATION

Date_____

Name_____Nick name_____Age_____

Date of birth_____ Sex_____ SSN_____

Whom may we thank for referring you to our office?_____

If not refer how did you hear about us?_____

RESPONSIBLE PARTY INFORMATION

Name_____SSN_____

Home Address _____

City_____State_____Zip_____

Home phone_____
Cell Phone_____would like to get text reminder for APPT. Yes No

Email Address(for appointment reminder) _____

Employer_____Occupation_____

Year's employed_____Work phone_____

Spouse name_____Cell phone_____

Relationship to patient_____

DENTAL INSURANCE INFORMATION

Do you have dental insurance? [ ] Yes [ ] No If Yes:

Insurance Co. Name_____ Insurance Co. Phone_____

Insurance Co. Address_____

Group #_____ID#_____

Primary Insured's Name _____Relationship to Patient_____

Insured's Birth Date_____SSN_____

Insured's Employer_____

Do you have dual coverage? Yes_____ No_____ If yes:

Insurance Co. Name_____ Insurance Co. Phone_____

Insurance Co. Address_____

Group #_____ID#_____

Primary Insured's Name _____Relationship to Patient_____

Insured's Birth Date_____SSN_____

Insured's Employer_____

MEDICAL HISTORY

Place check in the YES or NO column	Yes	No
1. Is your child allergic to any medications?_____	____	____
2. Have you child had any serious illness, operation, or hospitalization in the past?	____	____
3. Has there been a change in your child health in the last 2 years?	____	____
4. Is your child a "bleeder" or have you had excessive bleeding following dental treatment?	____	____
5. Is your child presently under the care of a physician?	____	____

6. Female Patients only:

Yes No Has menstruation started?

8. HAVE YOUR CHILD HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO		YES	NO
High Blood Pressure	___	___	Angina	___	___	Aids of related Complex	___	___
Heart Murmurs	___	___	Heart Attack	___	___	Blood disorders	___	___
Prolapsed Mitral Valve	___	___	Pacemaker	___	___	Joint Implants	___	___
Rheumatic Fever	___	___	Emphysema	___	___	Nervous Disorder	___	___
Heart Problems	___	___	Asthma	___	___	Epilepsy / Seizures	___	___
Heart Bypass Surgery	___	___	Dialysis	___	___	Steroids Last 2 Years	___	___
Kidney Disease	___	___	Tuberculosis	___	___	Radiation / Chemo	___	___
Chemical Dependency Treatment	___	___	Stroke	___	___	H.I.V. Positive	___	___
Hepatitis / Liver Disease	___	___	Diabetes	___	___			
Oral Surgery Complications	___	___	Arthritis	___	___	**Women Only:**		
Thyroid Disorders	___	___	Headaches	___	___	Pregnant	___	___
Bleeding Problems	___	___	Cancer	___	___	Breast Feeding	___	___

9. List **ANY** drugs or medicines that you are currently taking…include prescription / non-prescription drugs, Aspirin, Birth control pills, and vitamins.

DRUG	DOSAGE / HOW OFTEN?	HOW LONG?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physician name_____ Phone #_____

Last Seen/Reason_____

DENTAL HISTORY

General Dentist Name_____

Date of last visit_____Last cleaning date:_____

What concerns you most about your gum mouth or teeth?

_____

Yes No Are you presently in any dental pain?_____

Yes No Have there been any injuries to face, mouth, or teeth?_____

Yes No Is any part of your mouth sensitive to temperature? Where?_____

Yes No Is any part of your mouth sensitive to pressure? Where?_____

Yes No Do you have any type of thumb or tongue habit? _____

Yes No Have you ever seen and or treated by an orthodontist? If yes, who and when?_____

Yes No Do your teeth or jaws ever feel uncomfortable first thing in the morning? _____

Yes No Do you experience jaw clicking or popping?_____

Yes No Aware of clenching or grinding teeth during the day?_____

Yes No Have you ever experienced chronic ringing in the ears?_____

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history during the course of care. In addition, I authorize Dr. Le and the dental staffs to take photographs, x-rays and perform the necessary dental services I may need to perform a complete orthodontic evaluation.

Patient Signature_____Date_____