American Association of Orthodontists

CONFIDENTIAL

Medical Dental History Form for Patients Under Age 18

PATIENT

Date _____

Patient's last name _____ First name _____ Middle initial _____

Prefers to be called _____ Hobbies, activities _____

Birth date _____ Sex ☐ Male ☐ Female Social Security# _____

School _____ Grade _____ Email address(es) _____

Home address _____ City, State, Zip code _____

Home phone ( ) _____-_____ Cell phone ( ) _____-_____

PARENT/GUARDIAN

Custodial parent(s) name(s) _____

Patient lives with *(check all that apply)* ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandparent(s) ☐ Other _____

Father's full name _____ Title: ☐ Mr ☐ Dr ☐ Other_____

Occupation _____ Email address _____

Address *(if different)* _____

Home phone *(If different)* ( ) _____-_____ Cell phone ( ) _____-_____ Work phone ( ) _____-_____

Mother's full name _____ Title: ☐ Mrs ☐ Ms ☐ Dr ☐ Other_____

Occupation _____ Email address _____

Address *(if different)* _____

Home Phone *(If different)* ( ) _____-_____ Cell phone ( ) _____-_____ Work phone ( ) _____-_____

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 teeth?_____

How does your child feel about orthodontic treatment?_____

Who suggested that your child might need orthodontic treatment? _____

Why did you select our office? _____

Describe any previous orthodontic treatment or consultations. _____

Does your child play a musical instrument?_____

Brother/sister name _____ age _____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Brother/sister name _____ age _____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

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Brother/sister name _____ age _____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Have any other family members been treated in this office? Please name them. _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____

Address *(if different than page 1)* _____ City, State, Zip _____

Home phone ( ) _____-_____ Cell phone ( ) _____-_____ Email address(es) _____

Social Security # _____ Employer _____

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

MEDICAL INSURANCE

Policy holder's full name _____

Insurance Company _____

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 _____