KUJAK ORTHODONTICS

Health History Form

For Patients Under Age 18

Patient

First Name _____ Last Name _____MI _____Birthdate ___ /____/____Gender_____

Prefers to be called _____Hobbies/Interests _____

Home Address _____City, State, Zip Code_____

Whom may we thank for referring you? ☐ Dentist ☐ Friend (*name*) _____ ☐Other_____

Dental Office _____Dentist _____Last dental visit date_____

Medical facility where the patient receives care _____

☐ **I am aware that the patient will need to miss work/school in order to attend some orthodontic appointments.**

Parent/Guardian

Patient lives with (*check all that apply*) ☐ mother ☐ father ☐ stepmother ☐ stepfather ☐ grandparent(s)
☐ other – what is the relationship? _____

Father's full name _____ Birthdate __/__/____ Social Security # _____

Cell Phone _____Home Phone _____ Email Address_____

Address (*if different than patient address*)_____

Employer _____ Spouse's Name (*if applicable*) _____

Mother's full name _____ Birthdate __/__/____ Social Security # _____

Cell Phone _____Home Phone _____ Email Address_____

Address (*if different than patient address*)_____

Employer _____ Spouse's Name (*if applicable*) _____

Financial Responsibility

Who is financially responsible for this account? _____ Social Security #_____

Address (*if different than patient address*)_____Cell Phone _____

E-mail Address_____ Employer_____

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

_____

Dental Insurance

Primary Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Unsure

Policy holder's full name _____Birthdate ___ /___ /____Social Security # _____

Insurance Co. Name _____Insurance Co. Address _____

Employer _____ Group # _____ ID # _____

Secondary Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Unsure

Policy holder's full name_____ Birthdate ___ /___ /____Social Security # _____

Insurance Co. Name _____Insurance Co. Address _____

Employer _____ Group # _____ ID # _____

Continue to back side

Medical History

Now or in the past has the patient ever had:

Y N Intravenous medication for bone disorders or cancer such as bisphosphonates like Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate)?

Y N Oral medication for bone disorders such as bisphosphonates like Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate)?

Y N Birth defects or hereditary problems?

Y N Any injuries to the face, head, neck?

Y N Arthritis or joint problems?

Y N Endocrine or thyroid problems?

Y N Diabetes or low sugar?

Y N Kidney problems?

Y N Stomach ulcer, hyperacidity, acid reflux?

Y N Immune system problems?

Y N Cancer, tumor, radiation treatment orchemotherapy?

Y N Bone fractures or major injuries?

Y N History of osteoporosis?

Y N AIDS or HIV positive?

Y N Hepatitis, jaundice or other liver problem?

Y N Seizures, fainting spells, neurologic problem?

Y N Mental health disturbance or depression?

Y N Vision, hearing or speech problems?

Y N Polio, mononucleosis, tuberculosis, pneumonia?

Y N History of eating disorder (anorexia, bulimia)?

Y N High or low blood pressure?

Y N Excessive bleeding or bruising, anemia?

Y N Gonorrhea, syphilis, herpes, sexually transmitted diseases?

Y N Chest pain, shortness of breath, tire easily, swollen ankles?

Y N Skin disorder (other than common acne)?

Y N A consistent, well balanced diet?

Y N Heart defects, heart murmur, rheumatic heart disease?

Y N Angina, arteriosclerosis, stroke or heart attack?

Y N Frequent headaches or migraines?

Y N Asthma, sinus problems, hayfever?

Y N Tonsil or adenoid condition?

Y N Frequent ear infections, colds, throat infections?

Y N A habit of chewing tobacco, smoking, or vaping?

Y N Noticeable changes in your face or jaws?

Y N To take antibiotic pre-medication before dental procedures?

Y N Has puberty begun?

Is the patient allergic to or have reactions from:

Y N Latex (gloves, balloons)

Y N Metals (jewelry, clothing snaps)

Y N Acrylics

Y N Aspirin

Y N Ibuprofen (Motrin, Advil)

Other substances_____

Medications

Please list any medications that the patient takes:

_____

Dental History

Now or in the past has the patient ever had:

Y N Permanent or extra (supernumerary) teeth removed?

Y N Supernumerary (extra) or congenitally missing teeth?

Y N Chipped or injured primary or permanent teeth?

Y N Any sensitive or sore teeth?

Y N Jaw fractures, cysts, infections?

Y N Bleeding gums, bad taste or mouth odor?

Y N Any teeth treated with root canals or pulpotomies?

Y N Difficulty breathing through nose?

Y N "Gum boils", frequent canker sores or cold sores?

Y N Food impaction between the teeth?

Y N History of speech problems or speech therapy?

Y N Mouth breathing habit or snoring at night?

Y N Abnormal swallowing (tongue thrust)?

Y N Tooth grinding or clenching?

Y N Frequent oral habits (sucking finger, chewing pen, etc.)?

Y N Clicking, locking in jaw joints?

Y N Soreness in jaw muscles or face muscles?

Y N Teeth causing irritation to lip, cheek or gums?

Y N A diagnosis for gum disease or pyorrhea?

Y N Treatment for "TMJ" or "TMD" problems?

Y N Any broken or missing fillings?

Y N Ringing in ears, difficulty in chewing or opening jaw?

Y N Any serious trouble associated with previous dental treatment?

Y N A previous orthodontic consultation?

Females

Y N Is the patient pregnant? ☐ Unsure

Y N Has menstruation begun?

Y N Would the patient be able to tolerate appliances in the mouth, follow the Dr.'s instructions and take care of oral hygiene?

Signature Needed

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in the patient's medical status. I authorize the dental staff to perform any necessary dental services that the patient may need during diagnosis and treatment, with my informed consent. The office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

Parent Signature Date