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 ____ E-mail 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 If other, what is the relationship? _____

Father's full name _____ Title ☐ Mr. ☐ Dr. ☐ Other _____

Occupation _____ Email address _____

Address (*if different*) _____

Cell Phone (*if different*): _____ Home phone _____

Work phone _____

Mother's full name _____ Title ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other _____

Occupation _____ Email address _____

Address (*if different*) _____

Cell Phone (*if different*): _____ Home 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? _____

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

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 from page 1*)_____ City, State, Zip _____

Cell phone _____ Home phone _____

E-mail 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_____

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).

PATIENT HEALTH INFORMATION

Do you 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 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 _____

MEDICAL HISTORY

Now or in the past, has your child had:

☐ yes ☐ no ☐ dk/u Emotional, sensory or developmental issues?
☐ yes ☐ no ☐ dk/u Birth defects or hereditary problems?
☐ yes ☐ no ☐ dk/u Bone fractures, or major injuries?
☐ yes ☐ no ☐ dk/u Any injuries to face, head, neck?
☐ yes ☐ no ☐ dk/u Arthritis or joint problems?
☐ yes ☐ no ☐ dk/u Cancer, tumor, radiation treatment or chemotherapy?
☐ yes ☐ no ☐ dk/u Endocrine or thyroid problems?
☐ yes ☐ no ☐ dk/u Diabetes or low sugar?
☐ yes ☐ no ☐ dk/u Kidney problems?
☐ yes ☐ no ☐ dk/u Immune system problems?
☐ yes ☐ no ☐ dk/u History of osteoporosis?
☐ yes ☐ no ☐ dk/u Gonorrhea, syphilis, herpes, sexually transmitted diseases?
☐ yes ☐ no ☐ dk/u AIDS or HIV positive?
☐ yes ☐ no ☐ dk/u Hepatitis, jaundice or other liver problems?
☐ yes ☐ no ☐ dk/u Polio, mononucleosis, tuberculosis, pneumonia?
☐ yes ☐ no ☐ dk/u Seizures, fainting spells, neurologic problem?
☐ yes ☐ no ☐ dk/u Mental health disturbance or depression?
☐ yes ☐ no ☐ dk/u History of eating disorder (anorexia, bulimia)?
☐ yes ☐ no ☐ dk/u Frequent headaches or migraines?
☐ yes ☐ no ☐ dk/u High or low blood pressure?
☐ yes ☐ no ☐ dk/u Excessive bleeding or bruising tendency, anemia?
☐ yes ☐ no ☐ dk/u Chest pain, shortness of breath, tire easily, swollen ankles?
☐ yes ☐ no ☐ dk/u Heart defects, heart murmur, rheumatic heart disease?
☐ yes ☐ no ☐ dk/u Angina, arteriosclerosis, stroke or heart attack?
☐ yes ☐ no ☐ dk/u Skin disorder (other than common acne)?
☐ yes ☐ no ☐ dk/u Does your child eat a well-balanced diet?
☐ yes ☐ no ☐ dk/u Vision, hearing, or speech problems?
☐ yes ☐ no ☐ dk/u Frequent ear infections, colds, throat infections?
☐ yes ☐ no ☐ dk/u Asthma, sinus problems, hayfever?
☐ yes ☐ no ☐ dk/u Tonsil or adenoids removed?
☐ yes ☐ no ☐ dk/u Does your child frequently breathe through his/her mouth?
☐ yes ☐ no ☐ dk/u Has your child ever taken intravenous medication for bone disorders or cancer such as bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate)?
☐ yes ☐ no ☐ dk/u Has your child ever taken oral medication for bone disorders such as bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) ?

MEDICAL HISTORY continued

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

☐ yes ☐ no ☐ dk/u Latex (gloves, balloons)
☐ yes ☐ no ☐ dk/u Metals (jewelry, clothing snaps)
☐ yes ☐ no ☐ dk/u Acrylics
☐ yes ☐ no ☐ dk/u Local anesthetics (novocaine, lidocaine, xylocaine)
☐ yes ☐ no ☐ dk/u Aspirin
☐ yes ☐ no ☐ dk/u Ibuprofen (Motrin, Advil)
☐ yes ☐ no ☐ dk/u Penicillin
☐ yes ☐ no ☐ dk/u Other antibiotics
☐ yes ☐ no ☐ dk/u Plant pollens
☐ yes ☐ no ☐ dk/u Animals
☐ yes ☐ no ☐ dk/u Foods
☐ yes ☐ no ☐ dk/u Other substances _____

DENTAL HISTORY

Now or in the past, has the patient had:

☐ yes ☐ no ☐ dk/u Erupting teeth very early or very late?
☐ yes ☐ no ☐ dk/u Primary (baby) teeth removed that were not loose?
☐ yes ☐ no ☐ dk/u Permanent or extra (supernumerary) teeth removed?
☐ yes ☐ no ☐ dk/u Supernumerary (extra) or congenitally missing teeth?
☐ yes ☐ no ☐ dk/u Chipped or injured primary or permanent teeth?
☐ yes ☐ no ☐ dk/u Any sensitive or sore teeth?
☐ yes ☐ no ☐ dk/u Any lost or broken fillings?
☐ yes ☐ no ☐ dk/u Jaw fractures, cysts, infections?
☐ yes ☐ no ☐ dk/u Any teeth treated with root canals or pulpotomies?
☐ yes ☐ no ☐ dk/u Frequent canker sores or cold sores?
☐ yes ☐ no ☐ dk/u History of speech problems or speech therapy?
☐ yes ☐ no ☐ dk/u Difficulty breathing through nose?
☐ yes ☐ no ☐ dk/u Mouth breathing habit or snoring at night?
☐ yes ☐ no ☐ dk/u History of speech problems?
☐ yes ☐ no ☐ dk/u Frequent habit of thumb/finger sucking?
Current ___ Yes ___ No Age stopped _____
☐ yes ☐ no ☐ dk/u Frequent habit of tongue thrust?
Current ___ Yes ___ No Age stopped _____
☐ yes ☐ no ☐ dk/u Frequent habit of fingernail biting?
Current ___ Yes ____ No Age stopped _____
☐ yes ☐ no ☐ dk/u Frequent habit of lip sucking?
Current ___ Yes ____ No Age stopped _____
☐ yes ☐ no ☐ dk/u Teeth causing irritation to lip, cheek or gums?
☐ yes ☐ no ☐ dk/u Tooth grinding or clenching?
☐ yes ☐ no ☐ dk/u Clicking, locking in jaw joints?
☐ yes ☐ no ☐ dk/u Soreness in jaw muscles or face muscles?
☐ yes ☐ no ☐ dk/u Has your child been treated for “TMJ” or “TMD” problems?
☐ yes ☐ no ☐ dk/u Any broken or missing fillings?
☐ yes ☐ no ☐ dk/u Any serious trouble associated with previous dental treatment?
☐ yes ☐ no ☐ dk/u Has your child ever been diagnosed with gum disease or pyorrhea?

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

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_____

SUPPLEMENTAL HEALTH QUESTIONNAIRE

Orthodontic Treatment in the Era of COVID-19

If you have been exposed to a communicable disease, you may spread the disease to the orthodontist, orthodontic staff or other patients/parents in the practice. Therefore, prior to each appointment, we will be asking the following questions to reduce the chances of transmission:

Do you, your child, others accompanying you today or anyone else you have recently been in contact with have any of the following symptoms?

- **Fever** ***(defined as above 100.4° F degrees)*****?** ☐ Yes ☐ No
- **Chills?** ☐ Yes ☐ No
- **Cough?** ☐ Yes ☐ No
- **Sore Throat?** ☐ Yes ☐ No
- **Shortness of breath and/or trouble breathing?** ☐ Yes ☐ No
- **Persistent muscle pain, pressure or tightness in the chest?** ☐ Yes ☐ No
- **New loss of taste or smell?** ☐ Yes ☐ No

Have you or others accompanying you to today's appointment traveled outside of our local area or outside of the US within the past 14 days? ☐ Yes ☐ No

Have you, your child, others accompanying you today or anyone you have recently been in contact with tested positive for or been diagnosed as having COVID-19 or any other communicable disease? ☐ Yes ☐ No

If yes provide approximate dates of illness _____ through _____
(symptom start date) (symptom end date)

☐ I understand that if the answer to any of these questions is yes, I may be asked to reschedule today's orthodontic appointment to a later date.

_____
Patient Name

_____ _____
Parent/Guardian Name *(if applicable)* Relation

_____ _____
Patient/Parent/Guardian Signature Date

American Association of Orthodontists®

Developed in cooperation with AAOIC

CLEAR FORM

SHQE200522

SUPPLEMENTAL INFORMED CONSENT

Orthodontic Treatment in the Era of COVID-19

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, orthodontist, orthodontic staff and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment?

☐ Yes ☐ No

_____

Patient Name

_____ _____

Parent/Guardian Name *(if applicable)* Relation

_____ _____

Patient/Parent/Guardian Signature Date

American Association of Orthodontists®

Developed in cooperation with AAOIC

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CLEAR FORM

CHATHAM ORTHODONTICS
Jasenna Johnson, DDS, PLLC

422 N Holly Avenue
Siler City, NC 27344
919.799.7100
www.chathamorthonc.com

Dental Radiograph Consent Form

Patient: _____

Parent/Legal Guardian: _____

The use of dental radiographs, or x-rays, can facilitate the detection of dental problems early before serious damage is done to you or your child's teeth, gums and supporting bones and structures. Dental radiographs are a part of the comprehensive orthodontic oral examination and required for appropriate treatment planning. Your insurance might not cover the x-rays.

Please indicate which you would like us to do:

☐ You can take new x-rays, which may or may not be covered with my insurance; however, I know I am responsible to pay for the x-rays if my insurance company does not pay for the x-rays.

☐ I release Chatham Orthodontics from any responsibility for any and all condition(s) which may be present, yet remain undiagnosed, as a result of my refusal to have radiographs taken.

_____ _____

Signature of Patient
(Parent or legal guardian)

Date