stellar Family Orthodontics

Today's date: _____

New Patient Medical/ Dental History

Patient's Name: _____ Preferred Name: _____

Date of birth: _____ Gender: _____

If minor, lives with: Mother ___ Father ___ Grandparents ___ Foster Parents ___ Other _____

Name of person completing this form: _____ Relationship to Patient: _____

Primary Dentist: _____ Dentist's Phone: _____

Physician: _____ Physician's Phone: _____

Medical History: (Please fill out completely)

- ☐ Sickle Cell Anemia or Trait (describe) _____
- ☐ Blood disorder or anemia (describe) _____
- ☐ Bruises easily
- ☐ Blood Transfusions
- ☐ Tonsillectomy and/or adenoidectomy
  When _____
- ☐ Heart Condition
- ☐ Heart Murmur (Innocent or Pathologic)
- ☐ High/Low Blood Pressure
- ☐ Cystic Fibrosis
- ☐ Scarlet Fever
- ☐ Asthma
  Frequency _____ Meds_____
- ☐ Thyroid Disorder
- ☐ Measles, Mumps, Chicken Pox
- ☐ Malignant Hyperthermia
- ☐ Skin Disease - Eczema
- ☐ Hepatitis Type _____
- ☐ Chronic Ear Infections/Otitis Media (describe)
- ☐ Tuberculosis or Positive Result (When _____)
- ☐ Stomach or GI disorder (describe) _____
  G-tube? _____
- ☐ Is the patient or a parent pregnant
- ☐ Diabetes (describe) _____
- ☐ Cancer (describe) _____
- ☐ Seizure Disorder (describe) _____
- ☐ Learning Disability (describe) _____
- ☐ Autism Spectrum Disorder (describe) _____
- ☐ Neurologic Disorder/Hydrocephalus/Muscle Weakness
- ☐ ADD/ADHD/Hyperactivity (describe) _____
- ☐ Down's Syndrome (Mild, Moderate, Severe)
- ☐ Depression
- ☐ Anxiety
- ☐ Body Image issues
- ☐ Cerebral Palsy, Muscular Dystrophy
- ☐ Tuberculosis or Positive Result
  When _____
- ☐ Kidney Disease or Transplant
- ☐ Handicaps or disabilities: _____
- ☐ AIDS/HIV
- ☐ Joint Replacement
- ☐ Frequent headaches
- ☐ Cold sores.

Is patient currently taking any medications?	☐ Yes	☐ No	List:
Does patient have allergies?	☐ Yes	☐ No	List:
Is patient allergic to any medications?	☐ Yes	☐ No	Explain:
Hospital stays or significant injuries in the last 12 months?	☐ Yes	☐ No	List:
Is patient under care for any other conditions?	☐ Yes	☐ No	Explain:

Dental History: (Please fill out completely)

Check any concerns that apply.

- ☐ Clenching / Grinding of Teeth
- ☐ Lip Sucking / Biting
- ☐ Mouth Breathing
- ☐ Nail Biting
- ☐ Speech Problems
- ☐ Tongue Thrust
- ☐ Jaw Pain (TMJ)
- ☐ Thumb / Finger Sucking Ongoing or Age stopped _____

What are the main concerns that you want orthodontics to accomplish? _____

_____

Have you had a prior orthodontic evaluation? ____ Yes ____ No

List any musical instruments played: _____

Are there any missing or extra permanent teeth? _____

For Adolescents: Has puberty begun? ____ Yes ____ No

For Females: Has menstruation begun? If so, what age? _____ Or, indicate No ___

Signature

AUTHORIZATION: I understand that the information I have given is correct and to the best of my knowledge, and that it will be held in the strictest of confidence. I grant Stellar Family Orthodontics, and their trained staff consent to do an oral exam and take appropriate x-rays, I understand I will be consulted before another treatment is rendered. I understand that this information will be used by our dentists to help determine the appropriate and ideal orthodontic treatment. If there is any change in the medical status, I will inform the office immediately. I authorize the insurance company that I have provided the information for to pay Stellar Family Orthodontics all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize Stellar Family Orthodontics to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: _____ Date:_____

Relationship to the patient: _____