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Specializing In Orthodontics For Children & Adults

DENTAL HISTORY FORM- PATIENT UNDER 18 YEARS OLD
CONFIDENTIAL

DATE _____

PATIENT LAST NAME _____ **FIRST** _____ **MIDDLE** _____

BIRTHDATE _____ **AGE** _____ **GENDER** _____ **CELLPHONE #** _____

EMAIL: _____

PATIENT'S ADDRESS-STREET _____ **HOME #** _____

CITY _____ **STATE** _____ **ZIP CODE** _____

FATHER: FULL NAME _____ **DOB** _____

SS# _____ **EMPLOYED BY** _____ **WORK #** _____

MOTHER: FULL NAME _____ **DOB** _____

SS# _____ **EMPLOYED BY** _____ **WORK #** _____

PARENTS ARE: MARRIED DIVORCED SINGLE PARENT _____

INSURANCE COVERAGE PRIMARY DENTAL _____ **GROUP #** _____

POLICY HOLDER _____

SECONDARY DENTAL _____ **GROUP#** _____

POLICY HOLDER _____

PATIENT'S DENTIST _____ **PHONE #** _____

WHO MAY WE THANK FOR YOUR REFERRAL? _____

PATIENT'S PHYSICIAN _____ **PHONE #** _____

HAVE OTHER FAMILY MEMBERS BEEN SEEN FOR CONSULTATION OR TREATED BY DR LOTZOF? _____

NAMES: _____

FAVORITE SPORTS, HOBBIES & PASTIMES: _____

PATIENTS SCHOOL: _____

IN CASE OF EMERGENCY CONTACT: _____ **PHONE #** _____

****For the following questions circle yes, no or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.**

Yes	**no**	**dk/u**	**Does patient follow directions?**	**Yes**	**no**	**dk/u**	**Does patient brush his/her teeth conscientiously?**
Yes	**no**	**dk/u**	**Does patient have learning disabilities Or need extra help with instructions?**	**Yes**	**no**	**dk/u**	**Is patient sensitive, self conscious?**

MEDICAL HISTORY

Yes	**no**	**dk/u**	**Birth defects or hereditary problems?**	**Yes**	**no**	**dk/u**	**Bone fractures, any major accidents?**
Yes	**no**	**dk/u**	**Artificial / joint replacements?**				
Yes	**no**	**dk/u**	**Rheumatoid or arthritic conditions?**	**Yes**	**no**	**dk/u**	**Endocrine or thyroid problems?**
Yes	**no**	**dk/u**	**Kidney problems?**	**Yes**	**no**	**dk/u**	**Diabetes?**
Yes	**no**	**dk/u**	**Cancer or been treated for a tumor?**	**Yes**	**no**	**dk/u**	**Stomach ulcer or hyperacidity?**
Yes	**no**	**dk/u**	**Polio, mono, tuberculosis, pneumonia?**	**Yes**	**no**	**dk/u**	**Problems of the immune system?**
Yes	**no**	**dk/u**	**AIDS or HIV positive?**	**Yes**	**no**	**dk/u**	**Hepatitis, jaundice or liver problem?**
Yes	**no**	**dk/u**	**Fainting spells, seizures, epilepsy or Neurologic problem?**	**Yes**	**no**	**dk/u**	**Mental health or behavioral problem?**
Yes	**no**	**dk/u**	**Vision, hearing, tasting or speech difficulties?**	**Yes**	**no**	**dk/u**	**Loss of weight recently, poor appetite?**
Yes	**no**	**dk/u**	**Excessive bleeding, black and blue tendency, anemia or bleeding disorder?**	**Yes**	**no**	**dk/u**	**High or low blood pressure?**
Yes	**no**	**dk/u**	**Tires easily?**	**Yes**	**no**	**dk/u**	**Chest pains, shortness of breath?**

Yes	no	dk/u	Cardiovascular problem (heart murmur, heart trouble, attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects or rheumatic heart?)				
Yes	no	dk/u	Skin disorder?	Yes	no	dk/u	Does the patient have a normal/good diet?
Yes	no	dk/u	Allergies or drug reactions? If yes please describe_____				
Yes	no	dk/u	Allergy to latex?				
Yes	no	dk/u	Sensitivity to nickel?				
Yes	no	dk/u	Frequent headaches, colds, sore throat?				
Yes	no	dk/u	Tonsil or adenoid conditions?				
Yes	no	dk/u	Hayfever, asthma, sinus trouble, hives? If yes please describe_____				
Yes	no	dk/u	Is the patient taking medication, nutrient supplements or non prescription medicine? please list_____				
Yes	no	dk/u	Operations or surgical procedures?				
Yes	no	dk/u	Hospitalized for_____				
Yes	no	dk/u	Ear, nose, or throat condition?				
Yes	no	dk/u	Other physical problems or symptoms, being treated by another health care professional for_____				

Most recent exam date_____

DENTAL HISTORY

Yes	no	dk/u	Started teething very early or late?	Yes	no	dk/u	Baby teeth removed that were not loose?
Yes	no	dk/u	Permanent or extra teeth removed?	Yes	no	dk/u	Supernumerary (extra) or congenitally missing teeth?
Yes	no	dk/u	Chipped or otherwise injured primary (baby) or permanent teeth?	Yes	no	dk/u	Teeth sensitive to hot/cold, teeth throb or ache?
Yes	no	dk/u	Jaw fractures, cysts, mouth infections?	Yes	no	dk/u	"Dead teeth", root canal treated?
Yes	no	dk/u	Bleeding gums, bad taste, mouth odor?	Yes	no	dk/u	Periodontal "gum problems"?
Yes	no	dk/u	Food impacting between teeth?	Yes	no	dk/u	Frequent canker sores, cold sores?
Yes	no	dk/u	Is child taking fluoride?	Yes	no	dk/u	Thumb, finger, sucking habit?
Yes	no	dk/u	Abnormal swallowing (tongue thrust)?	Yes	no	dk/u	History of speech problems?
Yes	no	dk/u	Mouth breathing habit, snoring?	Yes	no	dk/u	Tooth grinding, jaw clenching, clicking, locking?
Yes	no	dk/u	Aware or concerned with over or under developed jaw?	Yes	no	dk/u	Does the patient experience any pain or soreness in the muscles in the face around the ears?
Yes	no	dk/u	Difficulty in chewing or opening the jaw?	Yes	no	dk/u	Aware of loose, broken, or missing fillings?
Yes	no	dk/u	Any teeth irritating cheek, lip, tongue, palate?	Yes	no	dk/u	Has patient had any serious trouble with previous dental treatment?
Yes	no	dk./u	Any pain in jaw or ringing in the ear?	Yes	no	dk/u	Any relative with similar tooth or jaw structure?
Yes	no	dk/u	Any wisdom tooth problems?	Yes	no	dk/u	Concerned with spaced, crooked, protruding, teeth?
Yes	no	dk/u	Onset of puberty? Date_____	Yes	no	dk/u	Has patient had prior orthodontic treatment?
Yes	no	dk/u	Has patient had periodontal treatment?	Yes	no	dk/u	If needed, will the pt wear orthodontic appliances?

MOST RECENT DENTAL EXAM How often does patient brush? floss?_____

WHAT IS THE PATIENT'S PRIMARY CONCERN (REASON FOR VISIT)?_____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment?_____

Please Note: we are not responsible to know your insurance benefits. It is the responsibility of the patient to know their benefits. We are only given a general breakdown of coverage from your insurance company. They do make mistakes in giving information. We expect them to be accurate, but we recognize that they are not always accurate with their information. Fine points of your benefits are in your benefits book that we do not have access to. We will try to assist you in understanding your coverage, but we cannot be held responsible if your insurance does not cover treatment. Additionally, I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Dr. Lawrence Lotzof. The patient is always responsible for the costs of their treatment and anything that is not covered by insurance. Please initial _____

I have read and understand the above questions. 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. If there are any changes later to this history record or medical/dental status I will so inform this practice.

I UNDERSTAND THAT COMPLETION OF THIS FORM PERMITS A CREDIT CHECK

_____

SIGNATURE DATE