World Class Dentistry **Medical – Dental History Form**

Date _____ **Under 18 Years of Age**

- **Patient**

Last Name _____ Legal First Name _____ Middle Initial _____

Date of Birth _____ M _____ F ____

Pediatrician/Primary Care _____ Phone _____

City, State _____ Last Visit _____

- **Parent/Guardian**

Last Name _____ **Legal** First Name _____ Middle Initial _____

Relationship to Patient _____ Home Phone _____

Cell Phone _____ Email address _____

Address _____ City _____ State _____ Zip _____

How did you hear about us?

Medical History

Please let us know if your child has or has had any of the following:

YES	NO	
		ADD/ADHD
		Anemia
		Asthma
		Autism
		Blood Pressure ____ High ____ Low
		Cerebral Palsy
		Chronic Hay Fever
		Cleft Lip/Palate
		Congenital Heart Defect
		Diabetes
		Downs Syndrome
		Epilepsy or Seizures
		Hearing Problems
		Heart Murmur
		HIV/Aids
		Juvenile Arthritis
		Pneumonia
		Psychiatric Care
		Rheumatic Fever
		Sensory or Speech Impairment
		Stutter or Lisp
		Vision Problems

YES	NO	
		History of a Major Illness
		List and When:
		History of Major Surgeries
		List and When:
		Often sick with colds and/or other infections?
		List and how often:
		Other Medical/Dental Conditions we should know about?
		List:
		Ever been involved in a serious accident?
		List and When:
		Eat a balanced Diet?
		Mouth Breather?
		Fingernail biter/Thumb Sucker?

Medications **PLEASE PRINT**

Prescription or Over-the- Counter or Vitamins

Rx/ OTC/ Vitamins	Dosage	Frequency

Insurance

YES	NO	
		Dental Insurance with Ortho Coverage?
		Company:

Patient _____

Allergies ____No known Allergies

YES	NO	
		Any Allergies?
		(Medications, Foods, Latex, Etc.)
		List:

Hygiene

Brush – How often?	
Waterpik- How often?	
Floss – How often?	
Fluoridated water/Mouth wash?	

Does patient Chew Tobacco?	Does patient smoke?	Does patient Vape?

Pediatric Dentist _____ Phone _____
City, State _____ Last Visit _____ Last X-rays _____

Previous Orthodontic History _____

To the best of my knowledge, all questions and information given on this form are accurate. I understand that providing the incorrect information can be dangerous to the patient's health. It is my responsibility to inform this dental office (World Class Dentistry) of any changes in medical status and to update any demographic information.

I authorize the release of any dental/medical information to insurance companies, or for legal documentation to process claims. I understand that I am responsible for all charges incurred for treatment, regardless of insurance coverage.

Parent/Guardian Signature: _____Date _____

Parent/Guardian Printed Name _____Relationship _____

Reviewed by Ortho Staff _____ Date _____

Reviewed by Doctor _____ Date _____