American Association of Orthodontists
My Life. My Smile. My Orthodontist.®

C A N A L E S
ORTHODONTICS

# 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 _____

Home Address _____ City, State, Zip code _____

Home Phone (____) _____ - _____ Cell Phone (____) _____ - _____

Please circle your preferred method(s) for receiving appt reminders: patient's email / parent's email / text msg

If text message, please the provide the following:

Description (patient's cell, mom/dad's cell, etc): _____ Mobile number: (____) _____ - _____

Coverage Provider (AT&T, Verizon, T-Mobile, etc): _____

## PARENT/GUARDIAN

Custodial parent(s) name(s) _____

Patient lives with (check all that apply): mother father stepmother stepfather grandparent(s) other _____

Father's full name _____ Title: Mr. Dr. Other_____

Occupation _____ Email address _____

Address (if different) _____

Home Phone (if different): (____) _____ - _____ Cell phone (____) _____ - _____ Work phone (____) _____ - _____

Mother's full name _____ Title: Mrs. Ms. Dr. Other_____

Occupation _____ Email address _____

Address (if different) _____

Home Phone (if different): (____) _____ - _____ Cell phone (____) _____ - _____ Work phone (____) _____ - _____

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

**I give Canales Orthodontics permission to release medical/dental information to the following persons:**

_____ _____ _____

## DENTIST

Patient's Dentist _____ Address, City, State _____

Last seen _____ Reason _____ Next appointment _____

Other dentists/dental specialists now being seen:

Name _____ Address, 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. _____

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

Full Name _____ Date of birth:_____ Social Security # _____- _____ - _____

Address (if different from page 1) _____ City, State, Zip _____

# Years at address _____ ☐ Own ☐ Rent Previous address in same local area? Y / N

Home phone (____)____-____ Cell phone (____)____-____ E-mail address _____

Primary Source of Income:

☐ Employed ☐ Unemployment compensation ☐ Other _____

☐ Retired ☐ None

Occupation (choose the best option):

☐ Professional/Executive ☐ Military - officer ☐ Trade/Technical ☐ Labor

☐ Sales/Administrative ☐ Military - enlisted ☐ Service ☐ None

Employer _____ # Years at Current Employer _____

**I give Canales Orthodontics permission to release financial information to the following persons:**

_____ _____ _____

## 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 _____

**Your answers are for office records only and are confidential. A thorough medical history is essential to a complete orthodontic evaluation. For the following, please mark yes, no, or don't know/understand (dk/u).**

## MEDICAL HISTORY

**Now or in the past, has your child had:**

| | |
|---|---|
| **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 adenoid condition? |
| **yes no dk/u** | Does your child frequently breathe through his/her mouth? |
| **yes no dk/u** | Has your child ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer? |
| **yes no dk/u** | Has your child ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders? |

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

| | |
|---|---|
| **yes no dk/u** | Local anesthetics (novocaine, lidocaine, xylocaine) |
| **yes no dk/u** | Latex (gloves, balloons) |
| **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** | Metals (jewelry, clothing snaps) |
| **yes no dk/u** | Acrylics |
| **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 oral habits (sucking finger, chewing pen, etc.)?

**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?

## PATIENT HEALTH INFORMATION

Do you think that any of your child's activities affect his/her face, teeth or jaws? If so, 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 _____

Do you take antibiotic pre-medication before any dental procedures? Yes No

Does the patient currently have (or ever had) a substance abuse problem? _____

Does your child chew or smoke tobacco? _____

Have you noticed any unusual changes in your child's face or jaws? _____

Any other physical problems? _____

## 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? _____

How often does your child brush? _____ Floss? _____

## RELEASE AND WAIVER

**I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.**

**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 medical or dental health.**

**I understand that this office reserves the right to verify the credit status of potential patients and/or those responsible for payment prior to extending credit for treatment fees and may use one or more credit reporting services.**

Signature _____

Date_____

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# AUTHORIZATION FOR USE AND DISCLOSURE OF PATIENT INFORMATION FOR OTHER PURPOSES

Please initial each line, as you deem appropriate, to give our office permission to use certain patient information for the specific purposes described below:

_____ Use of patient's name and/or photo on our welcome/bulletin board.

_____ Use of patients's name and/or photo on our website and Facebook page for the purpose of congratulations and recognition of accomplishments.

_____ Use of patient's clinical photos and x-rays in dental case presentations for education purposes.

## PHOTO RELEASE

I, the undersigned, do hereby relinquish any and all rights to photographs, portraits, prints, or other photographic reproductions captured with still, motion picture, video, digital or other cameras for use by Canales Orthodontics.

**You have the right to revoke this authorization at any time by giving written notice of your revocation to Canales Orthodontics. Based on the day of the month that the revocation is received, we may not be able to remove the patient's name or photo from an upcoming publication. However, all efforts will be made to fulfill your request.**

**Please be assured that neither refusal to sign this form nor revocation of permission already given will have any bearing on the patient's care and treatment in our practice.**

Patient's Name: _____

Patient's Signature: _____

Date:_____

If under 18 years of age,

Parent or Guardian Signature: _____

Date:_____

CANALES ORTHODONTICS, LLC

# ACKNOWLEDGEMENT OF RECEIPT OF HIPPA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of this office's HIPPA Notice of Privacy Practices.

_____
Patient Name (please print)

_____ _____
Patient Signature Date

**OR**

_____ _____
Signature of Personal Representative Date

Authority of Personal Representative to Sign for Patient (Check One):

_____Parent _____Guardian _____Power of Attorney _____Other:_____

****Please Note: It is your right to refuse to sign this Acknowledgement****

***For Office Use Only***

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____ _____
Signature of Staff Member Date