

Randall P. Rigsby D.M.D.

Welcome To Our Office



Date: _____

CONFIDENTIAL

**MEDICAL DENTAL HISTORY FORM FOR
PATIENTS UNDER 18 YEARS OF AGE**

Patient's Last Name: _____ First Name: _____ Middle Name/Initial: _____

Birth Date: _____ Age: _____ Sex: Male Female Prefers To Be Called: _____

Patient's Address: _____

Zip/Postal Code: _____ Home Phone No.: (_____) _____ - _____

E-mail address: _____ Cell phone/pager: _____

Attends School At: _____ Grade: _____ Musical Instruments Played: _____

Name Of Patient's Dentist: _____ Date Last Seen: _____

Name Of Patient's Physician (s): _____

Sports And/Or Hobbies: _____

Names and Ages of Other Children in the Family: _____

Other family members treated here: _____

Birth Father's Height _____ ft. _____ in. Birth Mother's Height _____ ft. _____ in.

Patient's Present Weight _____ lbs. Height _____ ft. _____ in.

Father's name: _____ Occupation: _____

Employed by: _____

E-mail address: _____ Cell phone/pager: _____

Mother's name: _____ Occupation: _____

Employed by: _____

E-mail address: _____ Cell phone/pager: _____

Name of Person Financially Responsible for this account: _____

Insurance Coverage For Orthodontic Treatment? Yes No

Primary Policy Holder's Name: _____ S.S.N./S.I.N.: _____

Birth Date: _____ Employed By: _____

Dental Insurance Company: _____ Group No. _____

Secondary Policy Holder's Name: _____ S.S.N./S.I.N.: _____

Birth Date: _____ Employed By: _____

Dental Insurance Company: _____ Group No. _____

Who suggested that your child might need orthodontic treatment? _____

Why did you select our office? _____

For the following questions mark yes or no. The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

PATIENT PROFILE

- yes no Does patient follow directions well?
- yes no Does patient brush his/her teeth conscientiously?
- yes no Does patient have learning disabilities or need extra help with instructions?
- yes no Is patient sensitive or self-conscious about teeth?

MEDICAL HISTORY

Now or in the past, has the patient had:

- yes no Birth defects or hereditary problems?
- yes no Bone fractures, any major accidents?
- yes no Rheumatoid or arthritic conditions?
- yes no Endocrine or thyroid problems?
- yes no Kidney problems?
- yes no Diabetes?
- yes no Cancer, tumor, radiation treatment or chemotherapy?
- yes no Stomach ulcer or hyperacidity?
- yes no Polio, mononucleosis, tuberculosis or pneumonia?
- yes no Problems of the immune system?
- yes no AIDS or HIV positive?
- yes no Hepatitis, jaundice or liver problem?
- yes no Fainting spells, seizures, epilepsy or neurological problem?
- yes no Mental health disturbance or behavioral problem?
- yes no Vision, hearing, tasting or speech difficulties?

- yes no Loss of weight recently, poor appetite?
- yes no History of eating disorder (anorexia, bulimia)?
- yes no Excessive bleeding or bruising tendency, anemia or bleeding disorder?
- yes no High or low blood pressure?
- yes no Tires easily?
- yes no Chest pain, shortness of breath or swelling ankles?
- yes no Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
- yes no Skin disorder?
- yes no Does the patient eat a well-balanced diet?
- yes no Frequent headaches, colds or sore throats?
- yes no Eye, ear, nose or throat condition?
- yes no Hayfever, asthma, sinus trouble or hives?
- yes no Tonsil or adenoid conditions?

Allergies or reactions to any of the following:

- yes no Local anesthetics (Novocaine or Lidocaine)
- yes no Aspirin
- yes no Ibuprofen (Motrin, Advil)
- yes no Penicillin or other antibiotics
- yes no Sulfa drugs
- yes no Codeine or other narcotics
- yes no Metals (jewelry, clothing snaps)
- yes no Latex (gloves, balloons)
- yes no Vinyl
- yes no Acrylic
- yes no Animals
- yes no Foods (specify) _____
- yes no Other substances (specify) _____
- yes no Is the patient taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

- yes no Does the patient currently have or ever had a substance abuse problem?
- yes no Does the patient chew or smoke tobacco?
- yes no Operations? Describe: _____
- yes no Hospitalized? For: _____
- yes no Other physical problems or symptoms?
Describe: _____
- yes no Being treated by another health care professional?
For: _____
Date of most recent physical exam? _____

Are there any other medical conditions that we should be aware of?

GIRLS ONLY

- yes no Has the patient started her monthly periods?
If so, approximately when? _____
- yes no Is the patient pregnant?

FAMILY MEDICAL HISTORY

Do the patient's parents or siblings have any of the following health problems? If so, please explain.

Bleeding disorders _____

Diabetes _____

Arthritis _____

Metabolic disturbances _____

Severe allergies _____

Unusual dental problems _____

Jaw size imbalance _____

Any other family medical conditions that we should know about?

DENTAL HISTORY

Now or in the past, has the patient had:

- yes no Started teething very early or late?
- yes no Primary (baby) teeth removed that were not loose?
- yes no Supernumerary (extra) or congenitally missing teeth?
- yes no Permanent or "extra" (supernumerary) teeth removed?
- yes no Chipped or otherwise injured primary (baby) or permanent teeth?
- yes no Teeth sensitive to hot or cold; teeth throb or ache?
- yes no Jaw fractures, cysts or mouth infections?
- yes no "Dead teeth" or root canals treated?
- yes no Bleeding gums, bad taste or mouth odor?
- yes no Periodontal "gum problems"?
- yes no Food impaction between teeth?
- yes no Thumb, finger, or sucking habit? Until what age? _____
- yes no Abnormal swallowing habit (tongue thrusting)?
- yes no History of speech problems?
- yes no Mouth breathing habit, snoring or difficulty in breathing?
- yes no Tooth grinding, jaw clenching clicking or locking?
- yes no Any pain in jaw or ringing in the ears?
- yes no Any pain or soreness in the muscles of the face or around the ears?
- yes no Difficulty encountered in chewing or jaw opening?
- yes no Aware of loose, broken or missing restorations (fillings)?
- yes no Any teeth irritating cheek, lip, tongue or palate?
- yes no Concerned about spaced, crooked or protruding teeth?
- yes no Aware or concerned about under or over developed jaw?
- yes no "Gum Boils", frequent canker sores or cold sores?
- yes no Taking any forms of fluoride?
- yes no Any relative with similar tooth or jaw relationships?
- yes no Had periodontal (gum) treatment?
- yes no Would patient object to wearing orthodontic appliances (braces) should they be indicated?
- yes no Any serious trouble associated with any previous dental treatment?
- yes no Ever had a prior orthodontic examination or treatment?

yes no

Been under another dentist's care?

Specialist _____

Other _____

Signature of Parent or Guardian: _____

Date: _____