kwongorthodontics

specializing in orthodontics for children & adults

Medical Dental History Form
for Patients Under Age 18

Date: _____

Patient Name Last _____First_____Middle Initial_____

Hobbies, activities_____ Prefers to be called_____

Birthdate: _____ Gender: Male/Female SS#_____

Home address_____City_____State_____Zip_____

Home Phone_____ Cell_____ E-mail address_____

Patient lives with (check all that apply) Mother___Father___Stepmother___Stepfather___Grandparent(s)___Other_

PARENT/GUARDIAN

Mother/Guardian:_____Birthdate:_____SS#_____

Address_____City_____State_____Zip_____

Home Phone_____Cell_____E-mail_____

Mother/Guardian Employer:_____Phone:_____

Occupation:_____

Address:_____City_____State_____Zip_____

Dental Insurance:_____Group#_____ID#_____

Father/Guardian:_____Birthdate:_____SS#_____

Address_____City_____State_____Zip_____

Home Phone_____Cell_____E-mail_____

Father/Guardian Employer:_____Phone:_____

Occupation:_____

Address:_____City_____State_____Zip_____

Dental Insurance:_____Group#_____ID#_____

Who is Financially Responsible for this account?_____

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

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MEDICAL INSURANCE

Policy holder's full name_____

Insurance company_____

AS A COURTESY, WE WILL BILL YOUR INSURANCE FOR YOU. ANY REMAINING BALANCE WILL BE YOUR RESPONSIBILITY. DO YOU AUTHORIZE PAYMENT DIRECTLY TO DENTIST?
YES_____NO_____

Signature: _____**Date**:_____

DENTIST

Dentist Name and Address _____City _____

State _____ Zip _____

Last seen _____Reason _____ Next appointment _____

Other dentists/dental specialists now being seen: Name _____

City _____ State _____ Reason _____

GENERAL INFORMATION

What concerns you about your child's teeth? _____

Who suggested that your child might need orthodontic treatment?_____

How does your child feel about orthodontic treatment? _____

Why did you select our office? _____

Describe any previous orthodontic treatment or consultation? _____

Does your child play a musical instrument? _____

Brother/sister name age had orthodontic treatment? Yes __No__ If yes, where? _____

Brother/sister name age had orthodontic treatment? Yes __No__ If yes, where? _____

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. _____

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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_ Endocrine or thyroid problems?
yes _no_ dk/u_ Diabetes or low sugar?
yes _no_ dk/u_ Kidney problems?
yes _no_ dk/u_ Cancer, tumor, radiation treatment or chemotherapy?
yes _no_ dk/u_ Stomach ulcer, hyperacidity, acid reflux?
yes _no_ dk/u_ Immune system problems?
yes _no_ dk/u_ History of osteoporosis?
yes _no_ dk/u_ Gonorrhea, syphilis, herpes, STD?
yes _no_ dk/u_ AIDS or HIV positive?
yes _no_ dk/u_ Hepatitis, jaundice or other liver problem?
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_ Vision, hearing, or speech problems?
yes _no_ dk/u_ History of eating disorder (anorexia, bulimia)?
yes _no_ dk/u_ High or low blood pressure?
yes _no_ dk/u_ Excessive bleeding or bruising, anemia?
yes _no_ dk/u_ Chest pain, shortness of breath, swollen ankles?
yes _no_ dk/u_ Heart defects, heart murmur, rheumatic 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_ Do you eat a well-balanced diet?
yes _no_ dk/u_ Frequent headaches or migraines?
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_ Do you frequently breathe through your mouth?

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 your child had:

yes _no_ dk/u_ Permanent or extra teeth removed?
yes _no_ dk/u_ 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_ Bleeding gums, bad taste or mouth odor?
yes _no_ dk/u_ Jaw fractures, cysts, infections?
yes _no_ dk/u_ Any teeth treated with root canals or pulpotomies?
yes _no_ dk/u_ "Gum boils," frequent canker or cold sores?
yes _no_ dk/u_ Speech problems or speech therapy?
yes _no_ dk/u_ Difficulty breathing through nose?
yes _no_ dk/u_ Food impaction between the teeth?
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_ Abnormal swallowing (tongue thrust)?
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_ Ringing in ears, difficulty in chewing or opening jaw?
yes _no_ dk/u_ Have you ever been treated for "TMJ" or "TMD" problems?
yes _no_ dk/u_ Any broken or missing fillings?
yes _no_ dk/u_ Any serious trouble associate with previous dental treatment?
yes _no_ dk/u_ Have you ever been diagnosed with gum disease or pyorrhea?
yes _no_ dk/u_ Have you ever had an orthodontic consultation or treatment before now

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PATIENT HEALTH INFORMATION

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 _____

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

Does your child chew or smoke tobacco? _____

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

Any other physical problems? _____

How often does your child brush? _____

How often does your child floss? _____

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?_____

RELEASE AND WAIVER

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

Signature _____

Date_____

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.

Signature _____

Date_____

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Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices. Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

Please sign this form below under the heading "acknowledgement" to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

List Patient Names (Print)

_____.
Parent/Guardian Signature

_____.
_____.
_____.
_____.

Date:_____.

For office use only Patient refused to sign The following circumstances prohibited the patient from signing the Acknowledgement:
An emergency situation prevented the patient from signing the Acknowledgement. _____. Office Personnel (signature) Office Personnel (Print name) Date:_____.

Patient Consent

Please sign this form below under the heading "consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

List Patient(s) Name (print)

_____.
Parent/Guardian Signature

_____.
_____.
_____.

Date:_____.