

CONFIDENTIAL



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**MEDICAL DENTAL HISTORY
(UNDER 18 YEARS OF AGE)**

Date _____

Patient's Last Name _____ First _____ Middle _____

Birthdate _____ Age _____ Sex _____ Home Phone No. _____

Name of Patient's Dentist _____ Name of Physician(s) _____

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 Endocrine or thyroid problems? |
| yes no dk/u Does patient brush his/her teeth conscientiously? | yes no dk/u Kidney problems? |
| yes no dk/u Does patient have learning disabilities or need extra help with instructions? | yes no dk/u Diabetes? |
| yes no dk/u Is patient sensitive, self-conscious? | yes no dk/u Cancer or been treated for a tumor? |

MEDICAL HISTORY

- | | |
|--|---|
| yes no dk/u Birth defects or hereditary problems? | yes no dk/u Polio, mono, tuberculosis, pneumonia? |
| yes no dk/u Bone fractures, any major accidents? | yes no dk/u Problems of the immune system? |
| yes no dk/u Rheumatoid or arthritic conditions? | yes no dk/u AIDS or HIV positive? |
| yes no dk/u Mental health or behavioral problems? | yes no dk/u Hepatitis, jaundice or liver problem? |
| yes no dk/u Vision, hearing, tasting or speech difficulties? | yes no dk/u Fainting spells, seizures, epilepsy or neurologic problems? |
| yes no dk/u Loss of weight recently, poor appetite? | yes no dk/u Hayfever, asthma, sinus trouble, hives? |
| yes no dk/u Excessive bleeding, black and blue tendency, anemia or bleeding disorder? | yes no dk/u Tonsil or adenoid conditions? |
| yes no dk/u High or low blood pressure? | yes no dk/u Allergies or drug reactions? |
| yes no dk/u Tires easily? | yes no dk/u Are you taking medication, nutrient supplements or non prescription medicine? Please name them. |
| yes no dk/u Chest pain, shortness of breath or swelling ankles? | _____ |
| yes no dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects or rheumatic heart)? | yes no dk/u Does the patient currently have or ever had a substance abuse problem? |
| yes no dk/u Skin disorder? | yes no dk/u Operations (surgical procedures)? |
| yes no dk/u Do you have a normal and good diet? | yes no dk/u Hospitalized for _____ |
| yes no dk/u Frequent headaches, colds or sore throat? | yes no dk/u Other physical problems or symptoms? |
| yes no dk/u Eye, ear, nose, throat condition? | yes no dk/u Being treated by another health care professional? |
| | For _____ |
| | Date of most recent physical exam? _____ |

DENTAL HISTORY

- | | |
|---|--|
| yes no dk/u Started teething very early or late? | yes no dk/u "Gum Boils," frequent canker sores, cold sores? |
| yes no dk/u Primary (baby) teeth removed that were not loose? | yes no dk/u Is child taking any forms of fluoride? |
| yes no dk/u Permanent or "extra" (supernumerary) teeth removed? | yes no dk/u Thumb, finger, sucking habit? Until _____ |
| yes no dk/u Supernumerary (extra) or congenitally missing teeth? | yes no dk/u Abnormal swallowing habit (tongue thrusting)? |
| yes no dk/u Chipped or otherwise injured primary (baby) or permanent teeth? | yes no dk/u History of speech problems? |
| yes no dk/u Teeth sensitive to hot or cold; teeth throb or ache? | yes no dk/u Mouth breathing habit, snoring, difficulty in breathing? |
| yes no dk/u Jaw fractures, cysts, mouth infections? | yes no dk/u Tooth grinding, jaw clenching, clicking, locking? |
| yes no dk/u "Dead teeth," root canals treated? | yes no dk/u Any pain in jaw or ringing in the ears? |
| yes no dk/u Bleeding gums, bad taste, mouth odor? | yes no dk/u Does the patient experience any pain or soreness in the muscles of the face, or around the ears? |
| yes no dk/u Periodontal "Gum Problems"? | yes no dk/u Difficulty encountered in chewing or jaw opening? |
| yes no dk/u Food impaction between teeth? | yes no dk/u Aware of loose, broken or missing restorations (fillings)? |

Confidential RESPONSIBLE PARTY Information

Date _____

Responsible Party Last Name _____ Marital Status: Married Single Divorced

First Name _____ Middle Name _____

Address _____ City _____ State _____ Zip _____

How long at this address? _____ Home# _____ Cell# _____

Previous Address (if less than 3 years)

Address _____ City _____ State _____ Zip _____

Social Security # _____ Birthdate _____ Relation to Patient _____

Employer _____ Occupation _____ # Years Employed _____

Spouse's Last Name _____ Relation to Patient _____

First Name _____ Middle Name _____

Social Security # _____ Birthdate _____ Cell# _____

Employer _____ Occupation _____ # Years Employed _____

Confidential Patient Information

Patient's Last Name _____ First Name _____

Address _____ City _____ State _____ Zip _____

Patient's Cell# _____

Emergency Contact

Name of nearest relative not living with you _____

Complete Address _____

Phone# _____ Relation to Patient _____

I understand that where appropriate, a credit bureau "soft" report may be obtained.

Signature (Parent's signature if patient is a minor) _____ Date _____

I authorize any release of information relating to this claim and authorize payment directly to Dr. Steven Brizendine. I understand that I am responsible for all costs of dental treatment.

_____ Date _____

Steven F. Brizendine DDS, MS, Inc

*** You May Refuse to Sign This Acknowledgment***

I have read this office's Notice of Privacy Practices. I may request a copy of this Notice at any time.

Print Name: _____

Signature: _____

Date: _____

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)

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Authorization for use of Photograph (s)

This office displays photographs of patients for the purpose of treatment and patient relations. Before a patient's photograph (s) is used, permission is obtained from the patient and the use of the photograph (s) is held to specific conditions.

Conditions

- The photograph (s) is to be displayed in a professional manner at this location only.
- Patient's personal information associated with the photograph (s) will be restricted.
- The photograph (s) will not to be displayed for marketing or commercial purposes outside of this office.
- If the photograph (s) is used for teaching treatment procedures, the photograph (s) will be altered to protect the identity of the patient.
- This authorization and the use of the patient's photograph (s) will terminate upon the completion of treatment.
- Patient has the right to revoke the use of their photograph (s) at anytime.

Authorization

By signing this authorization, you are permitting the use of your photograph (s) base upon the conditions of this authorization.

You understand that any changes in the conditions of this authorization and/or use of your photograph (s) will automatically terminate this authorization and the use of your photograph (s). You also understand that you may revoke this authorization and the use of your photograph (s) in writing at anytime.

I _____ (patient's name)
have read this authorization and therefore give permission for the use of my photograph (s). By doing so, I release this office of any liability that may result from the use of my photograph (s)

Patient's Signature

Date

If the patient is a minor (under 18 years of age), a parent or legal guardian must sign.

Parent or Guardian's Signature

Date