CONFIDENTIAL

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(es) _____

Home address _____ City, State, Zip code _____

Home phone _____ Cell phone _____

PARENT/GUARDIAN

Custodial parent(s) name (s) _____

Patient lives with (*check all that apply*) ☐ mother ☐ father ☐ stepmother ☐ stepfather ☐ grandparent(s)
☐ other If other, what is the relationship? _____

Father's full name _____ Title ☐ Mr. ☐ Dr. ☐ Other _____

Occupation _____ Email address _____

Address (*if different*) _____

Cell Phone (*if different*): _____ Home phone _____

Work phone _____

Mother's full name _____ Title ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other _____

Occupation _____ Email address _____

Address (*if different*) _____

Cell Phone (*if different*): _____ Home phone _____

Work phone _____

DENTIST

Patient's Dentist _____ Address, City, State _____

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? _____

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. _____

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. _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____

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

Cell phone _____ Home phone _____

E-mail address(es) _____

Social Security # _____ Employer_____

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

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_____

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 questions, mark yes, no, or don't know/understand (dk/u).

PATIENT HEALTH INFORMATION

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

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

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

Does your child chew or smoke tobacco? _____

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

Any other physical problems _____

MEDICAL HISTORY

Now or in the past, has your child had:

☐ yes ☐ no ☐ dk/u Emotional, sensory or developmental issues?
☐ 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 adenoids removed?
☐ yes ☐ no ☐ dk/u Does your child frequently breathe through his/her mouth?
☐ yes ☐ no ☐ dk/u Has your child ever taken intravenous medication for bone disorders or cancer such as bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate)?
☐ yes ☐ no ☐ dk/u Has your child ever taken oral medication for bone disorders such as bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) ?

MEDICAL HISTORY continued

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

☐ yes ☐ no ☐ dk/u Latex (gloves, balloons)
☐ yes ☐ no ☐ dk/u Metals (jewelry, clothing snaps)
☐ yes ☐ no ☐ dk/u Acrylics
☐ yes ☐ no ☐ dk/u Local anesthetics (novocaine, lidocaine, xylocaine)
☐ 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 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 habit of thumb/finger sucking?
Current ___ Yes ___ No Age stopped _____
☐ yes ☐ no ☐ dk/u Frequent habit of tongue thrust?
Current ___ Yes ___ No Age stopped _____
☐ yes ☐ no ☐ dk/u Frequent habit of fingernail biting?
Current ___ Yes ____ No Age stopped _____
☐ yes ☐ no ☐ dk/u Frequent habit of lip sucking?
Current ___ Yes ____ No Age stopped _____
☐ 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?

How often does your child brush?_____
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 child's orthodontic treatment to my dental and/or medical insurance company.

Parent/Guardian 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 child's medical or dental health.

Parent/Guardian Signature _____ Date_____

MEDICAL HISTORY UPDATES

Changes _____

Parent/Guardian Signature _____ Date_____

Dental Staff Signature _____ Date_____

Changes _____

Parent/Guardian Signature _____ Date_____

Dental Staff Signature _____ Date_____

Changes _____

Parent/Guardian Signature _____ Date_____

Dental Staff Signature _____ Date_____

LUFF ORTHODONTICS

LUFF ORTHODONTICS PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect our obligations.

PROTECTING PERSONAL HEALTHCARE INFORMATION

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the State of Alaska. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone – even family members – without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

COLLECTING PERSONAL HEALTHCARE INFORMATION

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

DISCLOSING PERSONAL HEALTHCARE INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fund-raising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal protected information in exchange for or receipt of financial remuneration.

Any branch in the protection of your personal health information including unauthorized acquisition, access, use, or disclosure will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your PHI.

YOUR RIGHTS AS OUR PATIENT

You have a right to request copies of your healthcare information in a variety of formats and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other that stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. We urge you to notify us immediately if you believe your rights have been violated. You can also notify the U.S. Department of Health and Human Services.

An expanded and complete copy of our Statement of Privacy Practices is available for your review.

Additional Disclosure Authorization: I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Luff Orthodontics. In addition to the allowable disclosures describes in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indication "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules).

PRINT PATIENT NAME _____ DATE OF BIRTH _____

PRINT RESPONSIBLE PARTY NAME (OVER 18 YEARS OLD) _____ DATE OF BIRTH _____

RESPONSIBLE PARTY SIGNATURE _____

TELEPHONE _____ TODAY'S DATE _____

PLEASE INDICATE AUTHORIZED PERSONS	CIRCLE ONE	
Patient's Immediate Family Example parents, children	YES	NO
Patient's Extended Family Example grandparents, grandchildren	YES	NO
Patient's Spouse (if applicable)	YES	NO
Other (please list name below)	YES	NO

_____