American Association of
Orthodontists

Date: _____

CONFIDENTIAL

American Association of Orthodontists
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 ❑ I Prefer To Be Called: _____

S.S.N./S.I.N.: _____ Home Phone No.: _____ Cell No.: _____

Patient's Address: _____ Email: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Attends School At: _____ Grade: _____

Musical Instruments Played: _____

Sports And/Or Hobbies: _____

No. of brothers and sisters: _____ Ages: _____

Other family members treated here: _____

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

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

Custodial Parent(s) or Guardian(s): _____

Phone No. (if different than patient's): _____

Address (if different than patient's): _____

City: _____ State/Province: _____ Zip/Postal Code: _____

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

Name of Patient's Dentist: _____ Phone No.: _____

Dentist's Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Date Last Seen: _____ Reason: _____

Name of Patient's Physician(s): _____

Phone No(s): _____

Physician's Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Date Last Seen: _____ Reason: _____

Who Is Financially Responsible For This Account?

Last Name: _____ First Name: _____ Middle Name/Initial: _____

Address (if different from patient's): _____ Email: _____

City: _____ State: _____ Zip: _____ Years at this address: _____

If less than five years, previous address: _____

City: _____ State: _____ Zip: _____

Cell No.: _____

Phone No. (if different than patient's): _____ S.S.N/S.I.N.: _____

Employer: _____ How many years? _____

Insurance Coverage for Dental Treatment? Yes ❑ No ❑ 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.: _____

Medical 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, 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.

PATIENT PROFILE

❑ yes ❑ no ❑ dk/u Does patient follow directions well?

❑ yes ❑ no ❑ dk/u Does patient brush his/her teeth conscientiously?

❑ yes ❑ no ❑ dk/u Does patient have learning disabilities or need extra help with instructions?

❑ yes ❑ no ❑ dk/u Is patient sensitive or self-conscious about teeth?

MEDICAL HISTORY

Now or in the past, have you had:

❑ yes ❑ no ❑ dk/u Birth defects or hereditary problems?

❑ yes ❑ no ❑ dk/u Bone fractures, any major accidents?

❑ yes ❑ no ❑ dk/u Rheumatoid or arthritic conditions?

❑ yes ❑ no ❑ dk/u Endocrine or thyroid problems?

❑ yes ❑ no ❑ dk/u Kidney problems?

❑ yes ❑ no ❑ dk/u Diabetes?

❑ yes ❑ no ❑ dk/u Cancer, tumor, radiation treatment or chemotherapy?

❑ yes ❑ no ❑ dk/u Stomach ulcer or hyperacidity?

❑ yes ❑ no ❑ dk/u Polio, mononucleosis, tuberculosis, pneumonia?

❑ yes ❑ no ❑ dk/u Problems of the immune system?

❑ yes ❑ no ❑ dk/u AIDS or HIV positive?

❑ yes ❑ no ❑ dk/u Hepatitis, jaundice or liver problem?

❑ yes ❑ no ❑ dk/u Fainting spells, seizures, epilepsy or neurological problem?

❑ yes ❑ no ❑ dk/u Mental health disturbance or depression?

❑ yes ❑ no ❑ dk/u Vision, hearing, tasting or speech difficulties?

❑ yes ❑ no ❑ dk/u Loss of weight recently, poor appetite?

❑ yes ❑ no ❑ dk/u History of eating disorder (anorexia, bulimia)?

❑ yes ❑ no ❑ dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?

❑ yes ❑ no ❑ dk/u High or low blood pressure?

❑ yes ❑ no ❑ dk/u Tired easily?

❑ 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, heart murmur or rheumatic heart disease)?

❑ yes ❑ no ❑ dk/u Skin disorder?

❑ yes ❑ no ❑ dk/u Does the patient eat a well-balanced diet?

❑ yes ❑ no ❑ dk/u Frequent headaches, colds or sore throats?

❑ yes ❑ no ❑ dk/u Eye, ear, nose or throat condition?

❑ yes ❑ no ❑ dk/u Hayfever, asthma, sinus trouble or hives?

❑ yes ❑ no ❑ dk/u Tonsil or adenoid conditions?

Allergies or reactions to any of the following:

❑ yes ❑ no ❑ dk/u Local anesthetics (Novocaine or Lidocaine)

❑ yes ❑ no ❑ dk/u Aspirin

❑ yes ❑ no ❑ dk/u Ibuprofen (Motrin, Advil)

❑ yes ❑ no ❑ dk/u Penicillin or other antibiotics

❑ yes ❑ no ❑ dk/u Sulfa drugs

❑ yes ❑ no ❑ dk/u Codeine or other narcotics

❑ yes ❑ no ❑ dk/u Metals (jewelry, clothing snaps)

❑ yes ❑ no ❑ dk/u Latex (gloves, balloons)

❑ yes ❑ no ❑ dk/u Vinyl

❑ yes ❑ no ❑ dk/u Acrylic

❑ yes ❑ no ❑ dk/u Animals

❑ yes ❑ no ❑ dk/u Foods (specify) _____

❑ yes ❑ no ❑ dk/u Other substances (specify) _____

❑ yes ❑ no ❑ dk/u 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 ❑ dk/u Does the patient currently have or ever had a substance abuse problem?

❑ yes ❑ no ❑ dk/u Does the patient chew or smoke tobacco?

❑ yes ❑ no ❑ dk/u Operations? Describe: _____

_____

❑ yes ❑ no ❑ dk/u Hospitalized? Describe: _____

_____

❑ yes ❑ no ❑ dk/u Other physical problems or symptoms? Describe: _____

_____

_____

❑ yes ❑ no ❑ dk/u 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 ❑ dk/u Has the patient started her monthly periods?
If so, approximately when? _____

❑ yes ❑ no ❑ dk/u 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 ❑ dk/u Started teething very early or 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 otherwise injured primary (baby) or permanent teeth?

❑ yes ❑ no ❑ dk/u Teeth sensitive to hot or cold; teeth throb or ache?

❑ yes ❑ no ❑ dk/u Jaw fractures, cysts or mouth infections?

❑ yes ❑ no ❑ dk/u "Dead teeth" or root canals treated?

❑ yes ❑ no ❑ dk/u Bleeding gums, bad taste or mouth odor?

❑ yes ❑ no ❑ dk/u Periodontal "gum problems"?

❑ yes ❑ no ❑ dk/u Food impaction between teeth?

❑ yes ❑ no ❑ dk/u Thumb, finger, or sucking habit? Until what age_____?

❑ yes ❑ no ❑ dk/u Abnormal swallowing habit (tongue thrusting)?

❑ yes ❑ no ❑ dk/u History of speech problems?

❑ yes ❑ no ❑ dk/u Mouth breathing habit, snoring or difficulty in breathing?

❑ yes ❑ no ❑ dk/u Tooth grinding or jaw clenching?

❑ yes ❑ no ❑ dk/u Any pain in jaw or ringing in the ears?

❑ yes ❑ no ❑ dk/u Any pain or soreness in the muscles of the face or around the ears?

❑ yes ❑ no ❑ dk/u Difficulty encountered in chewing or jaw opening?

❑ yes ❑ no ❑ dk/u Aware of loose, broken or missing restorations (fillings)?

❑ yes ❑ no ❑ dk/u Any teeth irritating cheek, lip, tongue or palate?

❑ yes ❑ no ❑ dk/u Concerned about spaced, crooked or protruding teeth?

❑ yes ❑ no ❑ dk/u Aware or concerned about under or over developed jaw?

❑ yes ❑ no ❑ dk/u "Gum boils", frequent canker sores or cold sores?

❑ yes ❑ no ❑ dk/u Taking any forms of fluoride?

❑ yes ❑ no ❑ dk/u Any relative with similar tooth or jaw relationships?

❑ yes ❑ no ❑ dk/u Had periodontal (gum) treatment?

❑ yes ❑ no ❑ dk/u Would you object to wearing orthodontic appliances (braces) should they be indicated?

❑ yes ❑ no ❑ dk/u Any serious trouble associated with any previous dental treatment?

❑ yes ❑ no ❑ dk/u Ever had a prior orthodontic examination or treatment?

❑ yes ❑ no ❑ dk/u Been under another dentist's care?

Specialist _____

Other _____

How often does your child brush: _____ floss: _____

What is your primary concern? Why are you here? _____

I have read and understand the above questions. 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. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: _____ Date Signed: _____
(Parent or Guardian)

Signed: _____ Date Signed: _____
(Dental staff member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

_____

_____

Signed: _____ Date Signed: _____
(Parent or Guardian)

Signed: _____ Date Signed: _____
(Dental staff member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

_____

_____

Signed: _____ Date Signed: _____
(Parent or Guardian)

Signed: _____ Date Signed: _____
(Dental staff member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

_____

_____

Signed: _____ Date Signed: _____
(Patient)

Signed: _____ Date Signed: _____
(Dental staff member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

_____

_____

Signed: _____ Date Signed: _____
(Patient)

Signed: _____ Date Signed: _____
(Dental staff member)

Notice of Privacy Practices Acknowledgement

Rodney D. Hyduk, DDS, MSD, PC
90 W. Square Lake Rd.
Troy, MI 48098

42450 Garfield
Clinton Twp. MI 48038

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Bill third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that a copy of your Notice of Privacy is available for review upon request, containing a more complete description of the uses and disclosures of my health information.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name:_____

Signature of Patient (Parent if Minor):_____

Relationship to Patient (if parent):_____

Date:_____

Office use only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason

INSURANCE INFORMATION

PATIENT INSURANCE INFORMATION DENTAL

PATIENT NAME (if dependent) — RELATION TO EMPLOYEE ( ) SELF ( ) SPOUSE ( ) CHILD ( ) OTHER

EMPLOYEE NAME

SS#/SIN OF EMPLOYEE — BIRTH DATE

EMPLOYER — UNION NO.

GROUP PLAN NAME — GROUP NO.

PRIMARY CARRIER NAME — POLICY NO.

SECONDARY CARRIER NAME — POLICY NO.

ITEM 3550 COLWELL 1.800.637.1140

PATIENT INSURANCE INFORMATION MEDICAL

PATIENT NAME (if dependent) — RELATION TO EMPLOYEE ( ) SELF ( ) SPOUSE ( ) CHILD ( ) OTHER

EMPLOYEE NAME

SS#/SIN OF EMPLOYEE — BIRTH DATE

EMPLOYER — UNION NO.

GROUP PLAN NAME — GROUP NO.

PRIMARY CARRIER NAME — POLICY NO.

SECONDARY CARRIER NAME — POLICY NO.

ITEM 3550 COLWELL 1.800.637.1140

AUTHORIZATION

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with all claims.

Patient or Parent/Guardian Signature Date Print Name