1655 Hillhurst Ave Suite 203, Los Angeles, CA 90027
p: (323) 663-4610 | e: Smile@LosFelizOrthodontics.com
losfelizorthodontics.com

Health History Form—18 years and under

Please fill out this form and bring to your first appointment.
Thank you for choosing us for your orthodontic care!

______________________ ______________ ______________________
Patient First **Middle** **Last**

Patient Information: Date: ___ / ___ / ___ **Who may we thank for telling you about our office?**______________________

Prefers to be called: ____________ Gender: ☐ M ☐ F Birthdate: ____/____/_____ Age: _____ School: ____________________ Grade:______

Graduates in (yrs) _____ Address: ______________________________ City: ______________ State: ____ Zip: _________

Home Phone: (_____) ______ - __________ Pt's Cell Phone: (_____) ______ - ___________ ____________Pt's Email: ______________________

Dentist: ____________________ City:______________ Phone: (_____) ______ - _________ Yrs. with DDS______ Last visit: ___/___/_____

Name of Physician: ____________________ City: ______________ Phone: (_____) ______ - __________

Other medical or dental specialists seen: ____________________ City:______________ Phone: (_____) _____ - __________

Other siblings/relatives seen by Dr. Yamada: ____________________ Relationship/s: ______________

MOTHER or ☐ Legal Guardian: ____________________ Prefers to be called: ______________ Financially Responsible for Pt: ☐ Yes ☐ No

Status: ☐ Single ☐ Married ☐ Remarried ☐ Separated ☐ Divorced ☐ Widowed ☐ Other:______________

☐ Address same as patient Address: ______________________________ City: ______________ State: ____ Zip: _________

Home Phone: (_____) ______ - __________ Cell Phone: (_____) ______ - __________ Email: ____________________ Birthdate: ___/___/_____

SSN: _____ - ____ - _______ Driver's License #: ______________ Best way to reach me: ☐ Phone ☐ Email ☐ Text ☐ All ☐ Other______________

Occupation: ______________ Employed by: ______________________________ Work Phone: (_____) _____ - ________

Dental Insurance? ☐No ☐Yes Provider: ______________ Coverage:__________ Group No:__________ Subscriber No:______________

Medical Insurance? ☐No ☐Yes Provider: ______________ Coverage:__________ Group No:__________ Subscriber No:______________

Orthodontic Insurance? ☐No ☐Yes Maximum: $______________ Flex plan: ☐ No ☐ Yes Deadline to file for next year: ______________

FATHER or ☐ Legal Guardian: ____________________ Prefers to be called: ______________ Financially Responsible for Pt: ☐ Yes ☐ No

Status: ☐ Single ☐ Married ☐ Remarried ☐ Separated ☐ Divorced ☐ Widowed ☐ Other:______________

☐ Address same as patient Address: ______________________________ City: ______________ State: ____ Zip: _________

Home Phone: (_____) ______ - __________ Cell Phone: (_____) ______ - __________ Email: ____________________ Birthdate: ___/___/_____

SSN: _____ - ____ - _______ Driver's License #: ______________ Best way to reach me: ☐ Phone ☐ Email ☐ Text ☐ All ☐ Other______________

Occupation: ______________ Employed by: ______________________________ Work Phone: (_____) _____ - ________

Dental Insurance? ☐No ☐Yes Provider: ______________ Coverage:__________ Group No:__________ Subscriber No:______________

Medical Insurance? ☐No ☐Yes Provider: ______________ Coverage:__________ Group No:__________ Subscriber No:______________

Orthodontic Insurance? ☐No ☐Yes Maximum: $______________ Flex plan: ☐ No ☐ Yes Deadline to file for next year: ______________

FINANCIAL RESPONSIBILITY (if other than above): ☐ Step Parent ☐ Grandparent ☐ Other: __________ Name:______________________

☐Address same as patient Address: ______________________________ City: ______________ State: ____ Zip: _________

Home Phone: (_____) ______ - __________ Cell Phone: (_____) ______ - __________ Email: ____________________ Birthdate: ___/___/_____

SSN: _____ - ____ - _______ Driver's License #: ______________ Best way to reach me: ☐ Phone ☐ Email ☐ Text ☐ All ☐ Other______________

Occupation: ______________ Employed by: ______________________________ Work Phone: (_____) _____ - ________

ADDITIONAL EMERGENCY CONTACT: Name______________________________Relationship to patient:______________

Address: ______________________________City______________State__________ Zip______________

Phone: (_____) ______ - __________ (_____) ______ - __________ (_____) ______ - __________ Email: ______________________
Home Cell Phone Work

Best way to reach me: ☐ Phone ☐ Email ☐ Text ☐ All ☐ Other______________

Last Revised: 06/13/2010

Patient Name:________________________ **Date**__________ Staff member reviewing:________________

MEDICAL & DENTAL HISTORY—*(Under 18)* Please answer the following questions with Yes or No to indicate if your child currently has or has a history of any of the conditions listed. If you checked Yes, please describe the specific condition and check the appropriate boxes. Let us know if you have questions. Thank you.

Current MEDICAL treatment or needs? ☐ No ☐ Yes
____
Good health, appetite, energy level? ☐ No ☐ Yes
Explain if no: ____________
Medications/drugs being taken now: ☐ No ☐ Yes
____
Need premedication for dental procedures? ☐ No ☐ Yes
☐ Antibiotics for heart murmur/valve
☐ Antibiotics for joint replacements
☐ Blood clotting aids ☐ Other:
Surgeries or hospitalizations? ☐ No ☐ Yes
☐ prior__________
☐ needed__________
Problems with the Immune System? ☐ No ☐ Yes
☐ Frequent infections ☐ AIDS
☐ HIV+ ☐ Other________
Liver problems? ☐ No ☐ Yes
Hepatitis? ☐ No ☐ Yes
Kidney problems? ☐ No ☐ Yes
Genito-urinary problems? ☐ No ☐ Yes
☐ Sexually transmitted diseases
☐ Other________
Illnesses, Diseases? ☐ No ☐ Yes
☐ Cancer ☐ Treatment for cancer
☐ Tuberculosis ☐ Polio
☐ Rheumatic/Scarlet Fever
☐ Other________
Endocrine or Hormonal problems? ☐ No ☐ Yes
☐ Hyperthyroid: ☐ Hypothyroid
☐ Other________
Skin disorders or sensitivies? ☐ No ☐ Yes
____

Injuries? ☐ No ☐ Yes
☐ Car accident ☐ Whiplash
☐ Other________
Drug reactions? ☐ No ☐ Yes
☐ penicillin ☐ other antibiotics
☐ ibuprofen (Advil, Motrin) or asprin
☐ Local anesthesia (novacaine, etc.)
☐ codeine ☐ Other:
Substance abuse problems? ☐ No ☐ Yes
Allergies (check all that apply)? ☐ No ☐ Yes
☐ latex ☐ metals
☐ acrylics ☐ seasonal
☐ milk ☐ other foods
☐ Other________
Heart Circulation? ☐ No ☐ Yes
☐ Heart murmur/Valve problem
☐ Blood Pressure: ☐ High ☐ Low
☐ Stroke ☐ Angina or chest pains
☐ Heart attack ☐ Heart surgery
☐ Need to take medication regularly
☐ Other________
Bleeding Problems? ☐ No ☐ Yes
☐ Hemophilia ☐ Bruise easily
☐ Bleed easily/excessively ☐ Anemia
☐ Other________
Blood Sugar? ☐ No ☐ Yes
☐ Low blood sugar/hypoglycemic
☐ High blood sugar/hyperglycemic
☐ Diabetic ☐ Needs medication
☐ Other________
Lungs/Breathing? ☐ No ☐ Yes
☐ Asthma ☐ Wheezing
☐ Shortness of breath
☐ Enlarged tonsils and adenoids ☐ removed
☐ Other________

Digestive System? ☐ No ☐ Yes
☐ Appendix removed ☐ Uclers
☐ Other________
Bones/Joints? ☐ No ☐ Yes
☐ History broken bone(s)
☐ Osteoporosis ☐ Joint Pain
☐ Arthritis ☐ Rheumatoid
☐ Fibromyalgia ☐ Other:
Sensory/Motor? ☐ No ☐ Yes
☐ Vision ☐ Hearing ☐ Speech
☐ Other________
Neurological? ☐ No ☐ Yes
☐ Fainting ☐ Dizziness
☐ Epilepsy ☐ Convulsions
☐ ADD/ADHD ☐ Other____
Pain? ☐ No ☐ Yes
☐ Face ☐ Body ☐ Back ☐ Jaw
☐ Other________
Psychological? ☐ No ☐ Yes
☐ Frequent anxiety ☐ Insomnia
☐ Depression ☐ Neurosis
☐ Psychiatric disorder
☐ Other________
Nose/Sinus? ☐ No ☐ Yes
☐ Frequent congestion ☐ Mouth breather
☐ Frequent sinus problems
☐ Other________
Reached Puberty? ☐ No ☐ Yes
Age:____ *(Signs include most rapid growth, menstruation for girls, voice change/facial hair for boys.)*
General Development is...
☐ Fast ☐ Slow ☐ Normal
☐ In rapid growth spurt ☐ Past growth spurt
Height:____ft____in
Weight:____ Shoe size:____

Current DENTAL needs? ☐ No ☐ Yes
____
History of injury to teeth? ☐ No ☐ Yes
____
Oral diseases? ☐ No ☐ Yes
☐ Oral or lip sores ☐ Herpes
☐ Other________
Problem teeth? ☐ No ☐ Yes
Sensitive teeth? ☐ No ☐ Yes
Missing or extra teeth? ☐ No ☐ Yes
Habits List or check below______
Finger, thumb, or lip habit? ☐ No ☐ Yes
Nail biting ☐ No ☐ Yes
Bite objects i.e., pens ☐ No ☐ Yes
Chew: ☐ ice ☐ gum ☐ No ☐ Yes
Taken Fluoride? ☐ No ☐ Yes
☐ Fluoride treatment at dentist
☐ Took oral supplements ☐ now taking
☐ Applies gel at home ☐ Fluoridated water

Abnormal Eruption? ☐ No ☐ Yes
☐ Had extractions to help crowding
☐ Impacted teeth ☐ Other:
Gum or periodontal problems? ☐ No ☐ Yes
____
Seeing specialists? ☐ No ☐ Yes
____
Jaw or TMJ problems? ☐ No ☐ Yes
Jaw click, pop or grating sound? ☐ No ☐ Yes
Jaw soreness, pain or stiffness? ☐ No ☐ Yes
Jaw locking or getting "stuck"? ☐ No ☐ Yes
Jaws sore or tired in morning? ☐ No ☐ Yes
Face/muscle aches? ☐ No ☐ Yes
Headaches? ☐ Moderate ☐ Migraines ☐ No ☐ Yes
History of trauma to face, jaws, teeth? ☐ No ☐ Yes
Previous jaw treatments? ☐ No ☐ Yes
☐ occlusal splint ☐ nightguard
☐ therapy ☐ medications

Oral or Jaw surgery? ☐ No ☐ Yes
Teeth removed:________
Previous Orthodontic Consultation? ☐ No ☐ Yes
Findings:________
Previous Orthodontic Treatment? ☐ No ☐ Yes
____________ Year____
Functional problems:
Tongue thrust? ☐ No ☐ Yes
Grinding/clenching teet ☐ No ☐ Yes
☐ Day ☐ Night ☐ Severe
Snoring? ☐ loud ☐ mild ☐ No ☐ Yes
Noisy breathing when sleeping? ☐ No ☐ Yes
Apnea or stops breathing during sleep ☐ No ☐ Yes
Difficulty breathing thru nose? ☐ No ☐ Yes
Excess tiredness after 8 hrs sleep? ☐ No ☐ Yes
Bedwetting ☐ No ☐ Yes
Acid reflux? ☐ No ☐ Yes
Difficulty memorizing or remembering ☐ No ☐ Yes
Constantly restless, fidgety, on the go ☐ No ☐ Yes

Have you taken intravenous bisphosphonates such as Zometa , Aredia, or Didronel for bone disorders or cancer? ☐ No ☐ Yes
Have you taken oral bisphosphonates such as Fosamax, Actonel, Boniva, Skelid or Didronel for bone disorders or cancer? ☐ No ☐ Yes

FAMILY MEDICAL HISTORY Have parents or siblings of the patient ever had any of the following:
☐ Bleeding disorder ☐ Arthritis ☐ Jaw pain or noises (TMJ) ☐ Periodontal disease ☐ Orthodontic extractions (not wisdom) ☐ Sleep Apnea
☐ Diabetes ☐ Severe allergies ☐ Jaw size /bite imbalance ☐ Orthodontic treatment ☐ Problems with dental treatment ☐ Other
Describe:________________

Are there any omissions in the medical or dental history? Please list below and/or provide clarifications to any of the above questions. ☐ No ☐ Yes
____

Realizing that successful treatment greatly depends upon complete cooperation following instructions, keeping appointments, maintaining oral hygiene and regular visits to your dentist, are there any restrictions, handicaps, or problems that might be encountered during treatment? ☐ No ☐ Yes
Describe:________________

I have read and understand the above questions and understand them. I will not hold my child's orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in completion of this form. I will notify my child's orthodontist in writing of any changes in my child's medical or dental health status.

____________ ______ ____________ ______
Parent's Signature *Date* *Doctor's Signature* *Date*