Culberson Family Orthodontics

1760 Knox Avenue North Augusta, SC 29841 803-279-0047

PATIENT MEDICAL AND DENTAL REPORT

FIRST NAME: _____ LAST NAME: _____
DATE: _____ ADDRESS: _____
AGE: _____ SEX: _____ BIRTHDATE: _____
PHONE: _____ CELL: _____
IS CHILD ADOPTED? _____ ARE PARENTS DIVORCED? _____
SCHOOL: _____

FATHER'S NAME: _____
EMAIL: _____
PHONE: _____ CELL: _____
SS#: _____ BIRTHDATE: _____
EMPLOYER: _____
INSURANCE COMPANY: _____
INSURED ID #: _____ GROUP #: _____

MOTHER'S NAME: _____
EMAIL: _____
PHONE: _____ CELL: _____
SS#: _____ BIRTHDATE: _____
EMPLOYER: _____
INSURANCE COMPANY: _____
INSURED ID #: _____ GROUP #: _____

Person responsible for payment: _____
Child lives with: _____
Number of brothers: _____ Number of sisters: _____
Physician: _____ Address: _____
Dentist: _____ Address: _____
Referred by: _____
Reason for ortho: _____
Is the patient taking any medication or under physicians care? _____
Has the patient ever had any extensive x-ray therapy? _____
Have tonsils and\or adenoids been removed? _____
List illnesses other than usual childhood diseases: _____
Does he\she grit, grind or clench teeth at night? _____
Bite nails lips, pencils, tongue, or other objects? _____
Suck on fingers, lips, or tongue? _____
List any injuries to face or mouth: _____
_____
Last dental visit: _____

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I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charged. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

_____ _____

Signed (patient, parent, or guardian) Date

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

_____ _____

Signed (patient, parent, or guardian) Date

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

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

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 Ibuprofin (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 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 oral habits (sucking finger, chewing pen, etc.)?
☐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?

PATIENT HEALTH INFORMATION

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

Does your child chew or smoke tobacco? _____

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

Any other physical problems? _____

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? _____

How often does your child brush? _____

Floss? _____

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 _____

Acknowledgement of Receipt of Notice of Privacy Practices

Culberson Family Orthodontics, LLC

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

I have received a copy of this office's Notice of Privacy Practices.

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)**