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WELCOME!

Signature of parent or guardian

Thank you for selecting our orthodontic healthcare team! We will strive to provide you with the best possible orthodontic care. Please complete both sides of this health history form in ink prior to coming to our office. All information will be kept confidential. If you have any questions or need assistance, please ask—we'll be happy to help.

MEDICAL-DENTAL HISTORY FORM FOR PATIENTS UNDER 18 YEARS OF AGE

| CONTACT INFORMATION: | | | | | | | | |
|--|--------------------------|----------------|------|--|--|--|--|--|
| Patient's name: (Last) (F | First) | (Middle) | | | | | | |
| Birthdate: / / Sex: Male () Female () | Home Phone: | | | | | | | |
| Patient's mailing address: | | | | | | | | |
| City/Town: | State: | Zip | | | | | | |
| Parent or Guardian's Name: | Relationship: | | | | | | | |
| Work Phone # | Cell Phone # | | | | | | | |
| Parent's marital status: Single () Married () Widowed | () Separated () Divord | ed () | | | | | | |
| In case we can not reach you: Person to contact: | | Phone: | | | | | | |
| | | | | | | | | |
| MEDICAL INFORMATION: (Please also complete question | s on back of this form) | | | | | | | |
| Name of patient's dentist: | Phone # () | | | | | | | |
| Address: | City/Town: | State: | Zip: | | | | | |
| Date of most recent dental examination: / / | | | | | | | | |
| How often does the patient brush their teeth? | Floss? | | | | | | | |
| Name of patient's primary care physician: | | Phone: | | | | | | |
| Address: | City/Town | State: | Zip: | | | | | |
| | | | | | | | | |
| PERSONAL INFORMATION: | | | | | | | | |
| Name of brothers and sisters (include ages): | | | | | | | | |
| Any other family members treated in our office? | | | | | | | | |
| Patient's present weight: | | | | | | | | |
| Patient's Interests: musical instrument played? Favorite sports? Hobby? | | | | | | | | |
| Patient's school: | | | | | | | | |
| | | | | | | | | |
| INSURANCE INFORMATION: | | | | | | | | |
| Orthodontic Insurance Coverage: Yes () No () | | | | | | | | |
| Primary (Dental) Insurance Company: | | Policy #: | | | | | | |
| Secondary (Dental) Insurance Company: | | Policy #: | | | | | | |
| Name of Insured: | | Phone #: | | | | | | |
| Social Security Number: | | Date of Birth: | | | | | | |
| Mailing address of insured: (if different than patient informatio | n above) | | | | | | | |
| City/Town: | | State: | Zip: | | | | | |
| Employer of Insured: | | Phone #: | | | | | | |
| Our office maintains strict confidentiality of all patient records. It is for that reason that we ask you to sign below as permission to release diagnostic findings to the patient's dentist. | | | | | | | | |

Date

For the following questions please circle YES/NO or DON'T KNOW (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. Thank you.

Yes No DK/U -Does the patient follow directions?

Yes No DK/U- Does the 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 the patient sensitive, self/conscious?

Medical History

Dental History

| Yes | no | dk/u | Mental health/behavioral problems? | , | Yes | no | dk/u | Started teething early or late? |
|---|-------|--------------|---|--------|-------|------|---|---|
| Yes | | | Vision, hearing, tasting or speech difficulties? | , | Yes | no | dk/u | Primary (baby) teeth removed |
| Yes | | | Loss of weight recently, poor appetite? | | * * | | 11 / | that were not loose? |
| | | | Do you have a normal diet? | | Yes | no | dk/u | Permanent or extra(supernumery |
| Yes | no | ak/u | Excessive bleeding, black and blue tendency, | | V | | J1_/_ | teeth removed)? |
| Vac | 200 | dk/u | Anemia or bleeding disorder? High or low blood pressure? | | res | no | dk/u | Supernumery(extra) or congenitally missing teeth? |
| | | dk/u | Tires easily? | | Vec | no | dk/u | Chipped or otherwise injured |
| | | | Cardiovascular problem (heart trouble, heart | | 1 03 | 110 | uk/u | primary (baby) or permanent |
| 1 03 | 110 | uk/ u | attack, angina, coronary insufficiency, arterioscle | erosis | | | | teeth? |
| | | | stroke, inborn heart defects or rheumatic heart)? | | Yes | no | dk/u | Teeth sensitive to hot or cold? |
| Yes | no | dk/u | Skin disorder? | | Yes | | dk/u | Jaw fractures, cysts, infections? |
| Yes | no | dk/u | Frequent headaches, colds, sore throats? | | Yes | no | dk/u | "Dead teeth" / root canals? |
| Yes | no | dk/u | Ear, nose, throat condition? | | Yes | no | dk/u | Bleeding gums, bad taste, mouth odor? |
| Yes | no | dk/u | Hayfever, asthma, sinus trouble, hives? | | Yes | no | dk/u | Periodontal "gum" problems? |
| Yes | no | dk/u | Tonsil or adenoid conditions? | | Yes | no | dk/u | Food impaction between teeth? |
| Yes | no | dk/u | Allergies or drug reactions? | | Yes | no | dk/u | "gum boils", frequent canker/cold sores? |
| Yes | no | dk//u | Are you taking medication, nutrient supplement | ts or | yes : | no | dk/u | Is child taking any form of fluoride? |
| | | | Non-prescription medicine? | _ | Yes | no | dk/u | Thumb, finger sucking habit? Until |
| | | | | Yes | no | dk/u | Abnormal swallowing (tongue thrust) problem? | |
| | | | | | Yes | no | dk/u | History of speech problems? |
| | | dk/u dk/u | Operations (surgical procedures)? Hospitalized for | | Yes | no | dk/u | Any pain in jaw or ringing in ears? |
| | | dk/u | Other physical problems or symptoms? | | Yes | no | dk/u | Does patient experience pain or |
| | | | | | | | | soreness in muscles of the face or around ears? |
| Da | te of | most 1 | recent physical exam? | | Yes | no | dk/u | Other physical problems or |
| | | | | | Vac | 200 | dle/m | symptoms? |
| Reali | zing | that si | accessful treatment greatly depends on the | | 168 | 110 | dk/u | Being treated by another health professional? |
| | | | te cooperation in following instructions, keeping | | Yes | no | dk/u | |
| | | | d maintaining oral hygiene, are there any | | 1 05 | 110 | an a | or jaw opening? |
| | | | dicaps or problems that might be encountered | | Yes | no | dk/u | Aware of loose, broken or missing |
| durin | g tre | atment | ? | | | | | restorations(fillings)? |
| | | | | | Yes | no | dk/u | Any teeth irritating cheek, lip, |
| | | | | | | | | tongue or palate? |
| | | | AND UNDERSTAND THE ABOVE | | Yes | no | dk/u | Concerned about spaced, crooked, |
| | | | WILL NOT HOLD MY ORTHODONTIST OR | - | | | | protruding teeth? |
| | | | OF HIS/HER STAFF RESPONSIBLE FOR OR OMISSIONS THAT I HAVE MADE IN | | Yes | no | dk/u | Aware or concerned about under or |
| THE COMPLETION OF THIS FORM. IF THERE ARE ANY | | | | Vac | | d1-/ | over-developed jaw? Any relative with similar tooth or | |
| CHANGES TO THIS HISTORY RECORD OR | | | | res | по | dk/u | jaw relationship? | |
| | | | NTAL STATUS I WILL SO INFORM THIS | | | | | Jaw relationship: |
| PRA | | | | | | | | |
| Signa | ture | | Date | - | | | | |