



SMITH

DENTAL SPECIALTIES

Douglas E. Smith, DDS
5102 Paulsen St., Bldg. 8, Savannah, GA 31405
912-655-8855 Phone / 912-257-4173 Clinical Fax

Medical/Dental History Form - Adolescent Intake Form

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

The information you provide in this packet is vital and will assist the doctor during the review of your child's symptoms. Please respond to all questions. Questions contained within are confidential and will become a part of your child's healthcare record. Some questions are intended for governmental/statistical purposes only.

PATIENT INFORMATION

Name: _____ Sex: F M
Last First Middle Initial

Home Address City State Zip Code

Date of Birth Height Weight Email Address

Social Security Number: _____ - _____ - _____

PATIENT CONTACT INFORMATION

Primary phone number: _____ Home Mobile Work Other
Alternate phone number: _____ Home Mobile Work Other
PREFERRED CONTACT: Phone Text Email Other _____

CONTACT & DISCLOSURE INFORMATION

Please provide contact name in case of an Emergency:

Name of individual Relationship to patient Primary phone #

Name of individuals to whom all of your information may be disclosed to:

Name of individual Relationship to patient Primary phone #

Name of individual Relationship to patient Primary phone #

If patient is a minor, please provide name of parents/guardians who is the responsible party:

Name of individual Relationship to patient Primary phone #

Name of individual Relationship to patient Primary phone #

PRIMARY / DENTAL INSURANCE INFORMATION

Primary Insurance Company		Subscriber ID	Group #
Subscriber's Last Name	Subscriber's First Name	Relationship to Patient	Date of Birth
Secondary Insurance Company		Subscriber ID	Group #
Subscriber's Last Name	Subscriber's First Name	Relationship to Patient	Date of Birth

PRIMARY / MEDICAL INSURANCE INFORMATION

Primary Insurance Company		Subscriber ID	Group #
Subscriber's Last Name	Subscriber's First Name	Relationship to Patient	Date of Birth
Secondary Insurance Company		Subscriber ID	Group #
Subscriber's Last Name	Subscriber's First Name	Relationship to Patient	Date of Birth

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account?: _____
 Address (if different than page 1): _____
 Home phone: _____ Cell phone: _____
 Email Address: _____ Social Security #: _____ - _____ - _____

HEALTHCARE PROVIDER INFORMATION

Dentist: _____ Phone #: _____
 Primary Care Doctor: _____ Phone #: _____
 Other Provider(s): _____ Phone #: _____

MEDICAL HISTORY – Now or in the past, has your child had:

Birth defects or heredity problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bone fractures or major injuries	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any injuries to the face, head, neck	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis or joint problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Endocrine or thyroid problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes or low sugar	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer, tumor, radiation treatment, or chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stomach ulcer, hyperacidity, acid reflux	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Immune system problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gonorrhea, syphilis, herpes, sexually transmitted diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No
AIDS or HIV positive	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis, jaundice, or other problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Polio, mononucleosis, tuberculosis, pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seizures, fainting spells, neurologic problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Mental health disturbance or depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vision, hearing, or speech problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of eating disorder (anorexia, bulimia, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High or low blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Excessive bleeding or bruising	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest pain, shortness of breath, tires easily, swollen ankles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Angina, arteriosclerosis, stroke or heart attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Skin disorder (other than common acne)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you eat a well-balanced diet	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Frequent headaches or migraines	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Frequent ear infections, colds, throat infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma, sinus problems, hay fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tonsil or adenoid condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No

DENTAL HISTORY – Now or in the past, has your child had:

Permanent or extra (supernumerary) teeth removed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Supernumerary (extra) or congenitally missing teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chipped or injured primary or permanent teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any sensitive or sore teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding gums, bad taste, or mouth odor	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Jaw fractures, cysts, infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any teeth treated with root canals or pulpotomies	<input type="checkbox"/> Yes	<input type="checkbox"/> No
“Gum boils”, frequent canker sores or cold sores	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of speech problems or speech therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty breathing through your nose	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Food impaction between the teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mouth breathing habit or snoring at night	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Teeth causing irritation to lip, cheek, or gums	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Abnormal swallowing (tongue thrust)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tooth grinding or clenching	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Clicking, locking in jaw joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Soreness in jaw or face muscles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ringing in ears, difficulty chewing or opening jaw	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been treated for “TMJ” or “TMD” problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any broken or missing fillings	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any trouble associated with previous dental treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been diagnosed with gum disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No

ALLERGIES – Has your child had allergies or reactions to any of the following:

Local anesthetics (Novocain, lidocaine, xylocaine)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Latex (gloves, balloons)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Aspirin	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Metals (jewelry, clothing snaps)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Penicillin	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other antibiotics: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ibuprofen (Motrin, Advil)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Acrylics	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Plant pollens	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Animals	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Foods	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please list any medications your child is taking: (Prescription or over the counter)

- _____
- _____
- _____
- _____
- _____

General Symptoms: Please check all that apply to your child

While sleeping does your child snore?	<input type="checkbox"/> Yes <input type="checkbox"/> No
While sleeping does your child break or pause while breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
While sleeping does your child sleep with their mouth open?	<input type="checkbox"/> Yes <input type="checkbox"/> No
While sleeping does your child sleep on their stomach?	<input type="checkbox"/> Yes <input type="checkbox"/> No
While sleeping does your child demonstrate restless or agitated sleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No
While sleeping does your child demonstrate abnormal head posture?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your child's pillow wet in the morning?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever noticed your child has difficulty breathing or with a lot of effort?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child fatigue easily after exercising?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child keep his/her mouth open while watching TV or using computer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child demonstrate poor posture while sitting or standing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child drool during the day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child eat with their lips open?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your child a messy eater?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child easily catch colds?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child have difficulty pronouncing sounds?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child have a history of the following:	<input type="checkbox"/> Thumb sucking <input type="checkbox"/> Finger sucking <input type="checkbox"/> Tongue sucking <input type="checkbox"/> Nail biting
Does your child grind or clench their teeth during the day or night?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> During the day <input type="checkbox"/> Only at night <input type="checkbox"/> Both

Has your child ever visited an ENT? If so, what for? _____
 What would you like your child to gain from therapy? _____
 What do you hope to achieve from this evaluation? _____
 Describe the problem your child is experiencing: _____
 What do you think caused the problem? _____
 What have you tried to fix the problem? _____
 How did you hear about our office? _____
 What concerns do you have about your child's teeth? _____
 Who suggested that your child be seen for treatment? _____
 Have you had any previous orthodontic treatment? _____
 Do any of your child's work or leisure activities affect his/her teeth or jaws? _____
 Does your child take antibiotic or pre-medication before any dental procedure? _____
 Does your child, or have they ever had a substance abuse problem? _____
 Do you chew or smoke tobacco? _____
 How often does your child brush their teeth each day? _____ How often do they floss? _____

RELEASE AND WAIVER

I authorize release of any information regarding my child's treatment to our dental and/or medical insurance company. I have read the above questions and understand them. I will not hold my child's orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I will notify Dr. Smith and his staff of any changes in my child's medical or dental health.

Signature of Responsible Party

Date

INFORMED CONSENT

for the Orthodontic Patient
Risks and Limitations of Orthodontic Treatment

- Successful orthodontic treatment is a partnership between the orthodontist and the patient. Dr. Smith and his staff are dedicated to achieving the best possible result for each patient. As a general rule, informed and cooperative patients can achieve positive orthodontic results. While recognizing the benefits of a beautiful healthy smile, you should also be aware that as with all healing arts, orthodontic treatment has limitations and potential risks. These are seldom serious enough to indicate that you should not have treatment; however, all patients should consider the option of no orthodontic treatment at all by accepting their present oral condition. Alternatives to orthodontic treatment vary with the individual's specific problem. You are encouraged to discuss alternatives with the doctor prior to beginning treatment.

- Allergies

Occasionally, patients can be allergic to some of the component materials of their orthodontic appliances. This may require a change in treatment plan or discontinuance of treatment prior to completion. Although very uncommon, medical management of dental material allergies may be necessary.

- General Health Problems

General health problems, such as bone, blood, or endocrine disorders, and many prescription and non-prescription drugs (including bisphosphonates) can affect your orthodontic treatment. It is imperative that you inform your orthodontist of any changes in your general health status.

- Use of Tobacco Products

Smoking or chewing tobacco has been shown to increase the risk of gum disease and interferes with health after oral surgery. Tobacco users are also more prone to oral cancer, gum recession, and delayed tooth movement during orthodontic treatment. If you use tobacco, carefully consider the possibility of a compromised orthodontic result.

- Acknowledgement

I hereby acknowledge that I have read and fully understand the treatment considerations and risks presented in this form. I also understand that there may be other problems that occur less frequently than those presented. I understand that actual results may differ from the anticipated results. I also acknowledge that I have discussed this form with Dr. Douglas Smith and have been given the opportunity to ask any questions. I have been asked to make a choice about my child's treatment. By signing below, I hereby consent to the treatment proposed, including radiologic services and authorize Dr. Smith and his staff to provide this treatment. I also authorize Dr. Smith and his staff to provide my child's health care information to his/her other health care providers. I understand that once released, Dr. Smith and his staff have no responsibility for any further release by the individual(s) receiving this information. I hereby consent to the making of diagnostic records, including pre-treatment and post treatment photos, x-rays before, during, and following orthodontic treatment. I understand that my child's treatment fee covers only treatment provided by the orthodontist and that treatment provided by other dental or medical professionals is not included in the fee for my child's orthodontic treatment.

Print Name

Signature

Date

Witness