BUENA VISTA ORTHODONTICS
MERILYNN YAMADA, D.D.S. & ASSOCIATES
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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

MEDICAL HISTORY – *(Under 18)*

Please answer the following questions with Yes or No to indicate if you have 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. Thanks.

Current medical treatment or needs? ☐ No ☐ Yes

_____
_____
_____

Good health, appetite, energy level? ☐ No ☐ Yes
Explain if no:
_____

Medications or drugs being taken now? ☐ No ☐ Yes

_____
_____
_____

Need premedications for dental procedures? ☐ No ☐ Yes
- ☐ Antibiotics for heart murmur/valve
- ☐ Blood clotting aids
- ☐ _____

Problems with the Immune System? ☐ No ☐ Yes
- ☐ Frequent infections
- ☐ AIDS ☐ Exposure to AIDS
- ☐ HIV+
- ☐ _____

Liver, Kidney, Genito-urinary problems? ☐ No ☐ Yes
- ☐ Hepatitis: ☐A ☐B
- ☐ Jaundice ☐ Venereal Disease
- ☐ _____

Surgeries, Hospitalizations? ☐ No ☐ Yes
_____

Skin disorders or sensitivities ☐ No ☐ Yes
- ☐ Rashes/Hives/Allergies

_____

Illnesses, Diseases? ☐ No ☐ Yes
- ☐ Diabetes ☐ Cancer
- ☐ Tuberculosis ☐ Polio
- ☐ Rheumatic/Scarlet Fever
- ☐ _____

Injuries? ☐ No ☐ Yes
- ☐ To face or jaws ☐ Broken bones
- ☐ Car accident
- ☐ _____

Drug reactions? ☐ No ☐ Yes
_____
_____

Allergies? ☐ No ☐ Yes
_____

Heart, Circulation? ☐ No ☐ Yes
- ☐ Heart murmur/Valve problem
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ _____

Blood? ☐ No ☐ Yes
- ☐ Hemophilia ☐ Anemia
- ☐ Bleeds easily/excessively
- ☐ Bruises easily
- ☐ _____

Blood Sugar? ☐ No ☐ Yes
- ☐ Low blood sugar/hypoglycemic
- ☐ High blood sugar/hyperglycemic
- ☐ Diabetic
- ☐ Needs Medication

Lungs, Breathing? ☐ No ☐ Yes
- ☐ Asthma ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Sleep apnea/abnormal snoring
- ☐ _____

Digestion system? ☐ No ☐ Yes
- ☐ Ulcers
- ☐ Appendix removed
- ☐ Nervous stomach
- ☐ _____

Bones, Joints? ☐ No ☐ Yes
- ☐ Break easily ☐ Osteoporosis
- ☐ Arthritis: (☐ Rheumatoid)
- ☐ Joint Pain
- ☐ _____

Sensory/Motor? ☐ No ☐ Yes
- ☐ Vision ☐ Hearing
- ☐ Taste/Smell ☐ Speech
- ☐ Coordination ☐ Hyper gag reflex
- ☐ _____

Neurological? ☐ No ☐ Yes
- ☐ Fainting ☐ Dizziness
- ☐ Epilepsy ☐ Convulsions
- ☐ Numbness/tingling
- ☐ _____

Pain? ☐ No ☐ Yes
- ☐ Face ☐ Body
- ☐ Headaches ☐ Neck
- ☐ Back ☐ Jaw
- ☐ Muscles ☐ Limbs
- ☐ _____

Psychological? ☐ No ☐ Yes
- ☐ Frequent anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ _____

Nose, sinus? ☐ No ☐ Yes
- ☐ Frequent congestion
- ☐ Frequently needs to breath through mouth
- ☐ _____

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:_____

DENTAL HISTORY

Current dental needs? ☐ No ☐ Yes

_____
_____

History of injury to teeth? ☐ No ☐ Yes
_____
- ☐ Trauma ☐ Fracture
- ☐ Root Canals

Oral diseases? ☐ No ☐ Yes
- ☐ Frequent cankor sores
- ☐ Fever/sun blisters
- ☐ Herpes
- ☐ _____

Problem teeth? ☐ No ☐ Yes
_____
- ☐ Sensitive or aching teeth to: ☐ cold ☐ hot ☐ pressure

Abnormal Eruption ☐ No ☐ Yes
- ☐ To Slow
- ☐ Requires extractions of baby teeth to facilitate eruption
- ☐ Ahead of schedule
- ☐ Impacted teeth

Gum or periodontal problems? ☐ No ☐ Yes
_____
_____

Jaw or TMJ problems? ☐ No ☐ Yes
- ☐ Click/pop ☐ Soreness
- ☐ Stiffness ☐ Locking
- ☐ Headaches ☐ Face/muscle aches
- ☐ Previous treatment

Describe right jaw:
_____
Describe left jaw:
_____

Missing or extra teeth? ☐ No ☐ Yes
_____

Oral or Jaw surgery? ☐ No ☐ Yes
Teeth removed:
_____

Taken Fluoride?
- ☐ Fluoride treatment at dentist
- ☐ Took oral supplements ☐ now taking
- ☐ Applies gel at home
- ☐ Fluoridated water

Habits? ☐ No ☐ Yes
- ☐ Finger sucking ☐ Lip biting or sucking
- ☐ Cheek biting ☐ Bites objects
- ☐ Abnormal swallowing
- ☐ Abnormal tongue thrust
- ☐ Snoring ☐ Chews ice
- ☐ Grinding/clenching teeth during day
- ☐ Can hear patient grinding at night
- ☐ _____

Previous Orthodontics? ☐ No ☐ Yes
Treatment:
_____
_____
Year:_____ ☐ Consultation Only

Family History of: ☐ No ☐ Yes
- ☐ Missing/Extra teeth
- ☐ Jaw alignment problems
- ☐ Jaw or TMJ problems
- ☐ Gum problems
- ☐ _____

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

_____

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? Describe: ☐ No ☐ Yes

_____

I have read and understand the above questions. I will not hold my orthodontist or any member of 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.

_____ _____

Signature of Parent or Guardian Date