BIERMANN ORTHODONTICS

Exceptional Smiles for Children and Adults

Minor Health History

Patient's Full Name _____Male ❑ Female ❑

Preferred name _____ Date of Birth _____ Age _____

Your HOME Address _____

City _____ State _____ Zip _____

Email address (for appointment reminders) _____

Home Phone: _____ Patient's Cell Phone: _____

Mom's Cell Phone: _____ Dad's Cell Phone: _____
We email appointment reminders, and also offer text message or phone call reminders upon request.

Name of the person accompanying the patient today? _____

What is your relationship to the patient? _____

With whom does the patient live? _____

Who should receive routine information about treatment progress? _____

Father's name: _____ Home Phone: _____

Address: _____ City, State, Zip: _____

Employer: _____Occupation: _____

Email Address: _____ Work Phone: _____

Mother's name: _____ Home Phone: _____

Address: _____ City, State, Zip: _____

Employer: _____Occupation: _____

Email Address: _____ Work Phone: _____

Is patient adopted? Yes ❑ No ❑ Are parents divorced/separated? Yes ❑ No ❑

Did biological mom or dad have orthodontic treatment? Yes ❑ No ❑ If so, for how long? _____

Patient's dentist _____ Last checkup date _____
(first and last name please)

How did you hear about us? _____

_____
Parent/ Guardian Initials

Do you have insurance coverage for orthodontic treatment for dependents? Yes ❑ No ❑

If yes, name of employer on policy: _____ Group #: _____

Primary policy holder's name: _____ Date of Birth: _____

Insurance company name: _____ ID #: _____

Patient's siblings: Name	Date of Birth	Needs/had braces?
_____	_____	Needs ❑ Had ❑ No ❑
_____	_____	Needs ❑ Had ❑ No ❑
_____	_____	Needs ❑ Had ❑ No ❑

DENTAL HISTORY:

What is your primary concern with your child's teeth? Why are you seeing us today, in your own words?

_____

_____

Does your child have or have they ever had? Check all that apply

❑ Braces
❑ Speech therapy
❑ Frequent headaches
❑ Jaws stick or lock
❑ Wisdom teeth extracted
❑ Food impaction/stuck between teeth
❑ Jaws "noisy" when they open and close
❑ Abnormal swallowing habit (tongue thrusting)
❑ History of speech problems
❑ Tooth grinding or jaw clenching
❑ Ever been treated for "TMD" or "TMJ"
❑ Teeth pulled
❑ Space maintainers
❑ Painful jaw joints
❑ Stiff neck
❑ Periodontal (gum) problems
❑ Had periodontal (gum) treatment
❑ Frequent canker sores or cold sores (circle)
❑ Ever had a prior orthodontic examination
❑ Mouth breathing habit, snoring or difficulty breathing
❑ Difficulty in chewing or jaw opening
❑ Any teeth irritating cheek, lip, tongue or palate
❑ Aware of loose, broken or missing restorations (fillings)
❑ Any pain or soreness in the muscles of the face, jaw or around the ears?
❑ Aware or concerned about under- or over-developed jaw(s)
❑ Thumb, finger, or sucking habit? Until what age_____?
❑ Any relative(s) with similar tooth or jaw issues
❑ Supernumerary ("extra")? Yes ❑ No ❑ If so, were they removed? Yes ❑ No ❑
❑ Any congenitally missing teeth? Explain:_____
❑ Had any serious trouble associated with any previous dental treatment. Explain: _____

_____

❑ Under another dental specialist's care? Name and reason:_____
❑ Other issues we should know about?_____

How often does your child brush?_____ Floss?_____

_____
Parent/ Guardian Initials

FAMILY MEDICAL HISTORY: Does your child's parents or siblings have any of the following:

Arthritis? Yes ❑ No ❑ Severe Allergies? Yes ❑ No ❑

Unusual dental problems? Yes ❑ No ❑ Jaw size imbalance? Yes ❑ No ❑

If yes to any of these, please explain:_____

_____

MEDICAL HISTORY: Does your child have or have they ever had? Check all that apply

❑ Birth defects or hereditary problems
❑ Rheumatoid or arthritic conditions
❑ Bone disease or osteoporosis
❑ Nutritional deficiencies
❑ Stroke(s)
❑ Skin disorder(s)
❑ Problems of the immune system
❑ Mental health disturbance or depression
❑ Vision, hearing, tasting difficulties
❑ Tuberculosis
❑ High or low blood pressure
❑ Eye, ear, nose or throat conditions
❑ Bone fractures, any major accidents
❑ Endocrine or thyroid problems
❑ Diabetes
❑ Cancer, tumor, radiation treatment or chemotherapy
❑ Tonsils/adenoids removed? ❑ Infected? ❑
❑ Stomach ulcer or hyperacidity
❑ Hepatitis, jaundice or liver problems
❑ Rheumatic fever
❑ History of eating disorder (anorexia, bulimia)
❑ Nasopharyngeal conditions
❑ Herpes
❑ Frequent headaches, colds or sore throats (circle)
❑ Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, inborn heart defects, heart murmur, rheumatic heart disease or heart valve issues)
❑ Fainting spells, seizures, epilepsy or neurological problem
❑ Asthma - how often is an emergency inhaler used for attacks?_____

❑ Any allergy-like sensitivity to alcohol?_____

❑ Other: _____

❑ Operations? describe_____

❑ Hospitalized? for_____

Please list all medications regularly taken; both prescription & over-the-counter drugs:

What ? Why ?

_____ _____

_____ _____

_____ _____

List anything your child is allergic to (penicillin, latex, etc.) _____

_____

_____
Parent/ Guardian Initials

Has your child ever had a significant blow to the face, head or a whiplash injury? Yes ❑ No ❑

Date_____ What part of the head?_____ Were teeth involved? Yes ❑ No ❑

Is there any illness or problem not listed that we should know about? Is there anything about your child's teeth, face or jaws that you would like to change? Please feel free to tell us anything else you feel we should know that may be related to your child's orthodontic, jaw, tooth, and/or jaw joint issues.

_____

_____

_____

_____

_____

_____

_____

Thank you for choosing us!
We're looking forward to meeting you!

Dr. Matthew C. Biermann
Orthodontics and Dentofacial Orthopedics

I, by my signature below, give permission for release of any pertinent information about my health that may be necessary for proper diagnosis and treatment of information regarding treatment to my dentist or other health professional. You have my permission to use clinical diagnostic materials such as x-rays, study models, photographic images, etc., in consultation with others regarding my treatment.

Signed: X_____Date Signed : _____
Parent/Guardian

Signed: X_____Date Signed : _____
Doctor

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