BIERMANN ORTHODONTICS

Minor Health History

Full Name _____

Name you prefer _____ Date of Birth _____ Age _____

Biological gender* at birth: ❑male ❑female Gender* that you best identify with: ❑male ❑female ❑other

Preferred Pronouns_____

*Because biologically male and female dentitions change and evolve at different ages we need to know this in order to create an accurate treatment plan.

Your HOME Address:_____

City _____ State _____ Zip _____

Preferred Phone: _____ Cell Phone: _____

Email address:_____

For communications from us do you prefer: ❑text ❑phone call ❑email

We send email appointment reminders and financial statements by email, and also offer text message or phone call reminders.

How did you hear about us? Or who should we thank for referring you to our office?

_____

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 info about treatment progress? _____

Father's name:_____

Employer: _____ Occupation: _____

Preferred Phone: _____ Cell Phone: _____

Email address:_____

Mother's name: _____

Employer: _____ Occupation: _____

Preferred Phone: _____ Cell Phone: _____

Email address:_____

Are parents divorced/separated? Yes ❑ No ❑

Is patient adopted? Yes ❑ No ❑

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

Dental Insurance:

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

If yes, name of employer on policy: _____

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

Group #: _____ ID #: _____

Insurance company name: _____

Insurance company phone: _____

General Dentist:

Your dentist _____ Last checkup date _____

(first and last name please)

What is your primary concern? Why are you seeing us today, in your own words? What would you like to change about your teeth/smile?

_____

_____

Are you interested in: ❑ Braces ❑ Invisalign

What is most important to you: ❑ Low monthly pay ❑ Short treatment time ❑ How soon you get started

DENTAL HISTORY: How often do you brush:_____ Floss _____

Do you now have or ever had? Check and/or circle all that apply

- ❑ Braces
- ❑ Nightguard
- ❑ Supernumerary ("extra") teeth.
- ❑ Congenitally missing teeth
- ❑ Difficulty in chewing or jaw opening
- ❑ Jaws stick or lock
- ❑ Frequent canker sores or cold sores
- ❑ Ever had a prior orthodontic examination
- ❑ History of speech problems
- ❑ Aware of loose, broken or missing restorations (fillings)
- ❑ TMJ splint
- ❑ Wisdom teeth extracted
- ❑ Pain in jaws
- ❑ Jaws "noisy" when you open and close
- ❑ Tooth grinding or jaw clenching
- ❑ Have you ever been treated for "TMD" or "TMJ"
- ❑ Abnormal swallowing habit (tongue thrusting)
- ❑ Thumb, finger, or sucking habit? Until what age_____?
- ❑ Mouth breathing habit, snoring or difficulty breathing
- ❑ Had periodontal (gum) treatment

❑ Any pain or soreness in the muscles of the face, jaws or around the ears?

❑ Aware or concerned about under or over developed jaw

❑ Any relative with similar tooth or jaw relationships (severe overjet, overbite, underbite...)

❑ Had any serious trouble associated with any previous dental treatment. Explain: _____

_____

❑ Under another dentist's or specialist's care? Name/reason:_____

Other dental issues we should know about_____

MEDICAL HISTORY: Do you now have or ever had? Check and/or circle all that apply

- ❑ Rheumatoid or arthritic conditions
- ❑ Bone disease or osteoporosis
- ❑ Stomach ulcer or hyperacidity
- ❑ Hepatitis
- ❑ Vision, hearing, tasting or speech difficulties
- ❑ Tuberculosis
- ❑ High or low blood pressure
- ❑ Bone fractures, any major accidents
- ❑ Endocrine or thyroid problems
- ❑ Seizures. If yes, how often? _____
- ❑ Diabetes
- ❑ Cancer, tumor, radiation treatment or chemotherapy
- ❑ Problems of the immune system
- ❑ History of eating disorder (anorexia, bulimia)
- ❑ Oral herpes
- ❑ Eye, ear, nose or throat conditions
- ❑ Frequent headaches, cold or sore throats
- ❑ Fainting spells, epilepsy or neurological problem.
- ❑ Tonsils removed?

❑ Asthma. How often do you use an emergency inhaler for attacks?_____

❑ Other: _____

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

_____

_____

_____

Allergies: List anything you are allergic to (penicillin, latex, etc.)

_____

Any operations/surgery? If yes, please describe_____

_____

Hospitalized? for_____

Have you ever had a significant blow to the face, head or a whiplash injury? Yes ❑ No ❑
Date?_____ What part of the head?_____ Were any teeth involved? Yes ❑ No ❑
Explain:

_____

_____

Is there any illness or problem not listed that we should know about? Is there anything about your teeth, face, nose, 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 orthodontic, jaw, tooth, and/or jaw joint problem.

_____

_____

_____

Do you, your parents or siblings have or ever had any of the following:
❑ Jaw size imbalance ❑ Unusual dental problems
If yes to any of these, please
explain_____

_____

Do you chew or smoke tobacco? Yes ❑ No ❑ Which (smoke or chew)?_____
If so how much?_____ If you have quit, when?_____

Have you ever taken bisphosphonates (for osteoporosis, bone density loss or cancer?) Yes ❑ No ❑

Women: are you pregnant? Yes ❑ No ❑ Are you anticipating becoming pregnant soon? Yes ❑ No ❑

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

Thank you for choosing us!
We're looking forward to meeting you!
Dr. Matthew C. Biermann DMD PC
Biermann Orthodontics