PDA DENTAL GROUP
PEDIATRIC | ORTHODONTIC | ADULT

955 Main Street, Suite 101 & G4 | Winchester, MA 01890 | 781-729-1900
54 Haven Street | Reading, MA 01867 | 781-944-7799
www.pdadentalgroup.com

ORTHODONTIC MEDICAL & DENTAL HISTORY

Patient's Last Name_____ Patient's First Name_____ M.I._____

Prefers to be Called_____ Birthdate_____ Home Phone # _____

Sex Assigned at Birth: ☐ Male ☐ Female Gender Identity:_____ Preferred Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them

Address_____City_____ State_____ Zip Code_____

PATIENTS UNDER 18 YEARS OLD

Legal Guardian #1 Name_____ Birthdate_____ SS #_____

Occupation/Employer_____ Cell Phone #_____ Email_____

Address_____ Relationship to Patient_____

Legal Guardian #2 Name_____ Birthdate_____ SS #_____

Occupation/Employer_____ Cell Phone #_____ Email_____

Address_____ Relationship to Patient_____

Guardian Marital Status: ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed ☐ Other_____

Name & Ages of Siblings_____

Dentist_____ Phone # _____ Pediatrician_____ Phone #_____

Extracurriculars/Sports/Hobbies_____

School_____ School's Location_____ Grade_____

How would you describe your child's dental experience? Check all that apply.
☐ Outgoing ☐ Cooperative ☐ Stubborn ☐ Anxious ☐ Shy ☐ Frightened ☐ Curious ☐ Friendly ☐ Defiant ☐ Other_____

PATIENTS OVER 18 YEARS OLD

Marital Status: ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed ☐ Other_____ SS #_____

Occupation/Employer_____ Email_____

Cell Phone #_____ Spouse/Closest Relative & Relationship to Patient_____

Dentist_____ Phone # _____ Physician_____ Phone #_____

DENTAL HISTORY

Reason for today's visit_____

Date of last dental exam_____ Have x-rays been taken? ☐ Yes ☐ No If yes, when & what type_____

Any injuries to face, mouth or teeth? ☐ Yes ☐ No If yes, when & which teeth_____ Cause of the injury _____

Does the patient have any of the following:

☐ Lip biting / Tongue thrusting
☐ Snoring / Mouth breathing
☐ Speech delays / Speech therapy
☐ Grinding / Clenching teeth
☐ Clicking / Popping of jaw / TMJ concerns
☐ Thumb / Finger sucking habit / Pacifier use
☐ Difficulty chewing / Swallowing / Gagging

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MEDICAL HISTORY

Current Physical Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Current Emotional Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list current medications _____

Please list any surgeries _____

Has the patient reached puberty ☐ Yes ☐ No If yes, approximate date_____

Does the patient have any allergies or unusual reactions? ☐ Latex ☐ Antibiotics/Medication ☐ Food ☐ Metals (jewelry, etc.) ☐ Other
If yes, please explain_____

Please check all medical conditions that apply to the patient:

☐ **Cardiac Disorders (Heart Related)**
- ☐ Congenital Heart Disease
- ☐ Previous Bacterial Endocarditis
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ High Blood Pressure

☐ **Lung/Airway Disease**
- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Adenoid/Tonsil Problems
- ☐ Chronic Ear Infections

☐ **Endocrine Disorders (Hormone Related)**
- ☐ Diabetes
- ☐ Hyper/Hypothyroidism
- ☐ History of Steroids

☐ **Gastrointestinal Disorders (Stomach Related)**
- ☐ Acid Reflux / GERD
- ☐ Nutritional Deficiency
- ☐ Inflammatory Bowel Disease (ie. Crohns)

☐ **Musculoskeletal Concerns**
- ☐ Joint Replacement

☐ **Substance Use**
- ☐ Tobacco
- ☐ Alcohol
- ☐ Drug:_____

☐ **Kidney or Bladder Problems**

☐ **Liver Disease**

☐ **Hematologic Concerns (Blood Related)**
- ☐ Hemophilia
- ☐ Anemia
- ☐ Sickle Cell Disease
- ☐ Transfusion of Blood

☐ **Infectious Diseases**
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐ Venereal Diseases (ie. Herpes, HPV):
  List:_____

☐ **Behavior & Learning Concerns**
- ☐ ADHD (ADD)
- ☐ Behavior Issues:
  List:_____
- ☐ Eating Disorder:
  List:_____
- ☐ Emotional/Psychiatric Disorder:
  List:_____
- ☐ Learning Disability:
  List:_____
- ☐ Speech Delay/Problems

☐ **History of Abuse (physical/psychological)**

☐ **Growth & Developmental Disorders**
- ☐ Autism Spectrum Disorder
- ☐ Anxiety/Nervousness
- ☐ Brain Injury/Cerebral Palsy
- ☐ Congenital Birth Defects
- ☐ Cleft Lip/Palate
- ☐ Depression
- ☐ Developmental Delay (Physical/Mental)
- ☐ Fainting/Dizziness/Frequent Headaches
- ☐ Feeding/Eating Problems
- ☐ Hearing Problems:
  List:_____
- ☐ Neuromuscular Defect
- ☐ Seizure History/Epilepsy
- ☐ Vision Problems

☐ **Miscellaneous**
- ☐ Cancer/Malignancies:
  List:_____
- ☐ Syndrome:
  List:_____

☐ **Other Conditions / Comments:**
_____
_____
_____
_____

If the patient does not have any medical conditions, please check here: ☐ None

Is there anything else you would like to tell us about the patient's medical/dental history?_____

Do you want to give us permission to speak to anyone else about your family's treatment or bill? ☐ Yes ☐ No
If yes, please specify who _____

How did you hear about us? ☐ Referral ☐ Social Media/Internet ☐ Community Event ☐ Family/Friends ☐ PDA Employee
☐ Medical Professional ☐ Other
Whom may we thank for referring you? _____

I certify that I have read and understand this information to the best of my knowledge. The questions have been accurately answered. It is my responsibility to inform the office of any changes in medical and/or dental status. I hereby give permission to PDA Dental Group to provide orthodontic treatment to this patient, which the doctor deems necessary and appropriate. Routine treatment may include, but not limited to, bonding braces, changing orthodontic wires, taking radiographs, etc.

Responsible Party's Signature_____ **Print Name** _____ **Date**_____