Dr. Alex JOHNSON Orthodontics

Health History Update
For Patients Under Age 18

PATIENT

First Name	Middle Name	Last Name		Today's Date	
Nickname	Birthdate	Age	Gender	SS#	
Address		City		State	Zip
Main Phone #		2nd/Cell Phone#			
Physician		Dentist			
School	Grade	Email Address			
Names of other family members in our orthodontic practice					
Who has legal custody of the patient?					

PARENTS/GUARDIANS

First Name	Middle Name	Last Name	Phone: Work Cell
Relationship to Patient			Email:
First Name	Middle Name	Last Name	Phone: Work Cell
Relationship to Patient			Email:

DENTAL HISTORY

Yes	No	dk/u	dk/u = don't know/unknown
☐	☐	☐	Tooth grinding or clenching?
☐	☐	☐	Clicking, locking or grinding noises in jaw joints?
☐	☐	☐	Soreness in jaw muscles or face muscles?
☐	☐	☐	Been diagnosed or treated for TMJ or TMD problems?
☐	☐	☐	Difficulty when chewing, jaw opening or TMJ issues?
☐	☐	☐	Pain, tenderness, or noise in either jaw joint?
☐	☐	☐	Neck/shoulder pain?
☐	☐	☐	Ever been diagnosed with gum disease?
☐	☐	☐	Ever had gum treatment or surgery?
☐	☐	☐	Jaw fractures, cysts, or infections?
☐	☐	☐	Chipped, injured primary (baby) or permanent teeth?
☐	☐	☐	Prior trauma or injury to the teeth, face, or neck?
☐	☐	☐	Has the patient been seen by their dentist recently? When? _____ What was done?_____ When scheduled to return?_____ How often does the patient see the dentist?_____

If any of the above medical questions were answered 'Yes', please explain:

AIRWAY/MYOFUNCTIONAL

Yes	No	dk/u	dk/u = don't know/unknown
☐	☐	☐	Difficulty breathing through nose? (stuffy nose)
☐	☐	☐	Mouth breathing during day?
☐	☐	☐	Mouth breathing while sleeping?
☐	☐	☐	Have a dry mouth on waking up in the morning?
☐	☐	☐	Drools while sleeping?
☐	☐	☐	Snores? ☐ occasional ☐ often ☐ routine ☐ seasonal ☐ when sick ☐ snores loudly
☐	☐	☐	Heavy or loud breathing while sleeping?
☐	☐	☐	Difficulty falling asleep or staying asleep?
☐	☐	☐	Is sleep unrefreshing or are bedsheets a mess?
☐	☐	☐	Frequently tired during the day?
☐	☐	☐	Ever had a sleep study? When?
☐	☐	☐	Ever been diagnosed with sleep apnea?
☐	☐	☐	Ever had myofunctional therapy?
☐	☐	☐	Oral habits, thumb, fingers, pencils, pens, other?
☐	☐	☐	Abnormal swallowing (tongue thrust)?
☐	☐	☐	History of speech problems or speech therapy? ☐ currently ☐ previously age:

Please include any other pertinent information below:

I understand that the information that I have given is correct to the best of my knowledge, and it is my responsibility to inform the office of any changes in the health status of the patient. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form.

Authorization is hereby granted for the orthodontic consultation and any necessary dental services that the patient may have during diagnosis and treatment with my informed consent. I grant permission to take photos of the patient to post within the office or website in conjunction with any contest that the patient may participate in while being present in the office. I authorize release of any information regarding the orthodontic treatment to my dental and/or medical insurance company.

Date _____

Signature _____ Relationship to Patient _____

Legal Guardian *(if different)* _____

MEDICAL HISTORY

Yes	No	dk/u	dk/u = don't know/unknown
☐	☐	☐	Is the patient in good health?
☐	☐	☐	Presently under care of a physician for a major illness?
☐	☐	☐	Any history of a major illness?
☐	☐	☐	Cardiovascular problem (heart defects, heart murmur, heart trouble, valve issues, or rheumatic heart disease)? Cardiologist: _____
☐	☐	☐	Antibiotic pre-medication needed for dental procedures?
☐	☐	☐	Rheumatic fever?
☐	☐	☐	Acid reflux issues?
☐	☐	☐	High or low blood pressure?
☐	☐	☐	Frequent headaches or migraines?
☐	☐	☐	Birth defects or hereditary problems?
☐	☐	☐	Emotional issues, anxiety, or depression?
☐	☐	☐	Autism, Asperger's or sensory issues?
☐	☐	☐	Cerebral palsy?
☐	☐	☐	Down syndrome?
☐	☐	☐	Any physical or emotional limitations?
☐	☐	☐	History of Eating Disorders/Bulimia/Anorexia?
☐	☐	☐	Seizures, Epilepsy, fainting spells, neurologic problems?
☐	☐	☐	Cancer, tumor, radiation, or chemotherapy?
☐	☐	☐	Endocrine or thyroid problems?
☐	☐	☐	Diabetes or low sugar?
☐	☐	☐	Kidney problems?
☐	☐	☐	Immune system problems?
☐	☐	☐	Excessive bleeding, bruising, anemia, or hemophilia?
☐	☐	☐	Chest pain, shortness of breath, or tire easily?
☐	☐	☐	Angina, arteriosclerosis, stroke, or heart attack?
☐	☐	☐	History of osteoporosis or osteopenia?
☐	☐	☐	Rheumatoid, osteoarthritis, or arthritic conditions?
☐	☐	☐	Bone disorders, bone fractures or major bone injuries?
☐	☐	☐	Ever taken oral or IV bisphosphonates such as Fosamax, Actonel, Boniva, Skelid, or Didronel for bone disorders?
☐	☐	☐	Vision, hearing problems, or skin disorders?
☐	☐	☐	Frequent colds, ear or throat infections?
☐	☐	☐	Asthma, sinus problems, or hay fever?
☐	☐	☐	Tonsil or adenoid issues?
☐	☐	☐	Gonorrhea, syphilis, herpes, or other STDs?
☐	☐	☐	AIDS or HIV positive?
☐	☐	☐	Hepatitis, jaundice, or other liver problems?
☐	☐	☐	Polio, mononucleosis, tuberculosis, or pneumonia?
☐	☐	☐	Diagnosed with ADD, ADHD?
☐	☐	☐	Poor attention span, difficulty focusing, hyperactive?
☐	☐	☐	Currently pregnant? (female patients)

If any of the above medical questions were answered 'Yes', please explain:

Any other medical conditions we should be aware of?

ALLERGIES

Yes	No	dk/u	dk/u = don't know/unknown
☐	☐	☐	Seasonal allergies?
☐	☐	☐	Routine allergies?
☐	☐	☐	Local anesthetics? (novocaine, lidocaine)
☐	☐	☐	Latex allergies? (gloves, balloons)
☐	☐	☐	Antibiotics or other medications? (list below)
☐	☐	☐	Metals? (jewelry, clothing snaps)
☐	☐	☐	Acrylics?

Please list any other allergies below:

SURGERIES

Yes	No	dk/u	dk/u = don't know/unknown	
☐	☐	☐	Tonsillectomy?	Age:
☐	☐	☐	Adenoidectomy?	Age:
☐	☐	☐	Nasal or Sinus?	Age:
☐	☐	☐	Cleft Lip/Palate?	Age:
☐	☐	☐	Frenectomy?	Age/Type:

Please include any other pertinent information below:

GROWTH STATUS

Yes	No	dk/u	dk/u = don't know/unknown
☐	☐	☐	Has the patient grown in the past year or has their shoe size or pant length changed recently?
☐	☐	☐	Is there a known history of any family member with an underbite (bottom teeth in front of the top teeth)? If yes, what is the relationship to the patient? _____
☐	☐	☐	If a child, has the patient reached puberty?
☐	☐	☐	If a girl, has she started her menstruation? Age? _____

Please include any other pertinent information below:

Please list any medications, nutritional supplements, herbal medications or non-prescription medications, including fluoride supplements that are currently being taken and what they are being taken for.

MEDICATION	REASON

FOR STAFF USE ONLY

SIGNIFICANT FINDINGS:	HEALTH ALERTS:
	ALLERGIES:
Follow-up needed:	
	Reviewed by: Date:
	Dr. Initials:

Alex J. Johnson, D.M.D., M.S.
Practice limited to orthodontics

Dr. Alex JOHNSON Orthodontics

(727) 786-7550

Agreement to Receive or Decline Electronic Communication

Patient Name: _____ Date of Birth: _____

☐ I agree that the dental practice may communicate with me electronically at the email address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails, therefore, all responses from the office of Dr. Alex Johnson will be sent through encrypted emails from any one staff member below:

Melanie@doctoralexjohnson.com
Nicole@doctoralexjohnson.com
Robin@doctoralexjohnson.com
Joy@doctoralexjohnson.com

I am responsible for providing the dental practice any updates to my email address.
I can withdraw my consent to electronic communication by calling: 727.786.7550

☐ I decline to have electronic communication by email with the office of Dr. Alex Johnson

Email Address (PLEASE PRINT CLEARLY):

_____@_____

Patient / Parent or Guardian Signature: _____Date: _____

Permission For Posting Patient Contest Participants Within the Office

I grant permission to the office of Dr. Alex Johnson to take photos of my child (the patient) or myself (as the patient) to post within the office or on our Facebook or Instagram pages, which are taken in conjunction with any contest that he/she or I participate in while at your office.

Patient / Parent or Guardian Signature: _____Date:_____