



TheBracePlace

JAMES IAN BALLOU, DDS

CONFIDENTIAL – MEDICAL DENTAL HISTORY FOR PATIENTS UNDER 18 YEARS OF AGE

James Ian Ballou, D.D.S.
2630 South Carrier Pkwy Ste A
Grand Prairie, TX 75052

T: (972) 660-5522
F: (972) 660-5525

Who can we thank for referring you to our office? _____
Responsible party's E-mail address: _____

Patient's Last Name: _____ First Name: _____ Middle Initial: _____

Birth Date: _____ Age: _____ Sex: Male Female Prefers to be Called: _____

S.S.N./S.I.N.: _____ Home Phone No.: _____

Patient's Address: _____

City: _____ State: _____ Zip/Postal Code: _____

School Name: _____ Grade: _____ Musical Instruments Played: _____

Sports and/or Hobbies: _____

No. of brothers and sisters: _____ Ages: _____

Other family members treated here: _____

Birth Father's Height: _____ ft. _____ in. Birth Mother's Height: _____ ft. _____ in.

Patient's Birth Weight: _____ lb. _____ oz. Patient's Present Weight: _____ lbs. Height: _____ ft. _____ in.

Father's name: _____ Home Phone: _____

Address: _____

Mother's name: _____ Home Phone: _____

Address: _____

PERSON RESPONSIBLE FOR ACCOUNT: _____

PRIMARY INSURANCE INFORMATION

Name of Insured: _____

Date of Birth: _____

Social Security #: _____

Employer: _____

Work Phone: _____

Employer Address: _____

City _____ State _____ Zip _____

Insurance Company: _____

Group #: _____

Address: _____

SECONDARY INSURANCE INFORMATION

Name of Insured: _____

Date of Birth: _____

Social Security #: _____

Employer: _____

Work Phone: _____

Employer Address: _____

City _____ State _____ Zip _____

Insurance Company: _____

Group #: _____

Address: _____

PATIENT PROFILE

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does patient follow directions well?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does patient brush his/her teeth conscientiously?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does patient have learning disabilities or need extra help with instructions?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is patient sensitive or self-conscious about teeth?

MEDICAL HISTORY : Now or in the past, has the patient had:

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Birth defects or hereditary problems?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bone fractures, any major accidents?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatoid or arthritic conditions?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Endocrine or thyroid problems?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney problems?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer, tumor, radiation treatment or chemotherapy?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stomach ulcer or hyperacidity?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Polio, mononucleosis, tuberculosis or pneumonia?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Problems of the immune system?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	AIDS or HIV positive?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis, jaundice or liver problems?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fainting spells, seizures, epilepsy or neurological problem?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mental health disturbance or behavioral problem?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vision, hearing, tasting or speech difficulties?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Loss of weight recently, poor appetite?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	History of eating disorder (anorexia, bulimia)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bleeding disorder, bruising tendency, excessive bleeding or anemia?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	High or low blood pressure?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tires easily?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chest pain, shortness of breath or swelling ankles?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin disorder?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the patient eat a well-balanced diet?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Frequent headaches, colds or sore throats?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Eye, ear, nose or throat condition?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hayfever, asthma, sinus trouble or hives?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tonsil or adenoid conditions?

GIRLS ONLY

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has the patient started her monthly periods?
		If so, approximately when? _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the patient pregnant?

Allergies or reactions to any of the following:

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Local anesthetics (Novocaine or Lidocaine)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Aspirin?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ibuprofen (Motrin, Advil)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Penicillin or other antibiotics?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sulfa drugs?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Codeine or other narcotics?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Metals (jewelry, clothing snaps)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Latex (gloves, balloons)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vinyl?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Acrylic?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Animals?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Foods (specify)? _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other substances (specify)? _____

Yes No Is the patient taking medication, nutrient supplements, herbal medications or non-prescription medicine? Please name them.

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the patient currently have or ever had a substance abuse problem?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the patient chew or smoke tobacco?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Operations? (specify) _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hospitalized? (for) _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other physical problems or symptoms? (describe) _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Being treated by another health care professional? (for) _____
		Date of most recent physical exam: _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are there any other medical conditions that we should be aware of?

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

Signed: _____ Date signed: _____
(Parent or Guardian)

Signed: _____ Date signed: _____
(Dental Staff Member)

DENTAL HISTORY: Now or in the past, has the patient had:

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Started teething very early or late?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Primary teeth removed that were not loose?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Permanent or "extra" (supernumerary) teeth removed?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chipped or otherwise injured teeth?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Teeth sensitive to hot or cold; throb or ache?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Jaw fractures, cysts or mouth infections?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	"Dead teeth" or root canals treated?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bleeding gums, bad taste or mouth odor?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Started teething very early or late?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Periodontal "gum" problems?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Food impaction between teeth?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thumb, finger, or sucking habit?
		Until what age? _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Abnormal swallowing habit (tongue thrust)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	History of speech problems?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mouth breathing habit, snoring or difficulty in breathing?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tooth grinding, jaw clenching, clicking or locking?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any pain in jaw or ringing in the ears?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any pain or soreness in the muscles of the face or around the ears?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Difficulty in chewing or jaw opening?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any loose, broken, or missing fillings?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Concerns about his/her profile?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Concerns about spaced, crooked or protruding teeth?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Aware or concerned about under or over developed jaw?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	"Gum Boils," canker sores or cold sores?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Taking any forms of fluoride?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any relative with similar tooth or jaw relationships?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Had periodontal (gum) treatment?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Would patient object to wearing orthodontic appliances (braces) should they be indicated?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any serious trouble associated with any previous dental treatment?

Name of Patient's Dentist: _____ Phone No. _____

Dentist's Address: _____ City: _____ State: _____ Zip _____

Yes No Has the patient ever had a prior orthodontic examination or treatment?

Doctor's name: _____ Date of treatment: _____

What is your primary concern? Why are you here? _____

I have read and understand the above questions. 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. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: _____ Date signed: _____
(Parent or Guardian)

Signed: _____ Date signed: _____
(Dental Staff Member)