



Dr. Kresimir P Lackovic

DMD, MSc, Cert Ortho, FRCD(C), Dip ABO

Specialist in Orthodontics and Dentofacial Orthopaedics

Medical Dental History Form

PATIENT

Date _____
Patient's Last name _____ First name _____ Middle initial _____
Preferred Name _____
Birth date _____ Sex: Male Female School _____ Grade _____
Home address _____ City _____ Prov _____ Postal code _____
Home phone (_____) _____ Cell phone (_____) _____ Work phone (_____) _____
E-mail address _____

PARENT/GUARDIAN (for patients less than 18 years of age)

Custodial parent(s) name (s) _____
Patient lives with (*check all that apply*) mother father stepmother stepfather grandparent(s) Other _____

Father's full name _____ Title Mr. Dr. Other _____
Birthdate _____ Email address _____
Address (*if different than patient address*) _____
Home phone (*if different*): (_____) _____ Cell phone (_____) _____ Work phone (_____) _____

Mother's full name _____ Title Mrs. Ms. Dr. Other _____
Birthdate _____ Email address _____
Address (*if different than patient address*) _____
Home phone (*if different*): (_____) _____ Cell phone (_____) _____ Work phone (_____) _____

DENTAL INSURANCE

Primary policy holder's full name _____ Birthdate _____
Relationship to patient _____ Address and phone (if not listed above) _____
Employer _____ Address _____
Insurance company _____ Group # _____ ID# _____
Does this policy have orthodontic benefits? Yes No Don't know

Secondary policy holder's full name _____ Birthdate _____
Relationship to patient _____ Address and phone (if not listed above) _____
Employer _____ Address _____
Insurance company _____ Group # _____ ID# _____
Does this policy have orthodontic benefits? Yes No Don't know

330 Bronte Street S, Unit 118 • Milton, ON
905 878.8988

925 Rathburn Road E, Suite D1 • Mississauga, ON
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• www.morphoorthodontics.com •



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FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____

Address (if different than patient address) _____

Home phone (_____) _____ Cell phone (_____) _____ E-mail address _____

Employer: _____

Who will be responsible for bringing the patient to orthodontic appointments? _____

DENTIST (If patient currently does not have a family dentist, please check the box)

Patient's Dentist _____ Address _____

Last seen _____ Reason _____

Other dentists/dental specialists being/recently seen: Name _____ City _____ Prov. _____

Reason _____

GENERAL INFORMATION

What concerns you or your child about **his/her** teeth? _____

How does your child feel about orthodontic treatment? _____

Who suggested that your child might need orthodontic treatment? _____

Why did you select our office? _____

Describe any previous orthodontic treatment or consultations _____

Do you/does your child play a musical instrument? _____

Brother/sister name _____ age _____ had orthodontic treatment? Yes No If yes, where? _____

Brother/sister name _____ age _____ had orthodontic treatment? Yes No If yes, where? _____

Brother/sister name _____ age _____ had orthodontic treatment? Yes No If yes, where? _____

Have any other family members been treated in this office? Please name them. _____

What are your main expectations? (Please check **one**) Excellent results? Efficient results? Affordable pricing?

PHYSICIAN

Patient's Physician _____ Address _____

Last seen _____ Reason _____ Next appointment _____

Most recent physical exam _____

Other physicians/health care providers being seen now:

Name _____ City _____ Prov _____

Reason _____

Name _____ City _____ Prov _____

Reason _____

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Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation. For the following questions mark yes, no, or don't know/understand (dk/u).

MEDICAL HISTORY

Now or in the past, have you had:

- yes no dk/u Birth defects or hereditary problems?
- yes no dk/u Bone fractures, or major injuries?
- yes no dk/u Any injuries to face, head, neck?
- yes no dk/u Arthritis or joint problems?
- yes no dk/u Endocrine or thyroid problems?
- yes no dk/u Diabetes or low sugar?
- yes no dk/u Kidney problems?
- yes no dk/u Cancer, tumor, radiation treatment or chemotherapy?
- yes no dk/u Immune system problems?
- yes no dk/u History of osteoporosis?
- yes no dk/u Gonorrhea, syphilis, herpes, STD's?
- yes no dk/u AIDS or HIV positive?
- yes no dk/u Hepatitis, jaundice or other liver problem?
- yes no dk/u Polio, mononucleosis, tuberculosis, pneumonia?
- yes no dk/u Seizures, fainting spells, neurologic problem?
- yes no dk/u Mental health disturbance or depression?
- yes no dk/u Vision, hearing, or speech problems?
- yes no dk/u History of eating disorder (anorexia, bulimia)?
- yes no dk/u High or low blood pressure?
- yes no dk/u Excessive bleeding or bruising, anemia?
- yes no dk/u Chest pain, short of breath, tire easily, swollen ankles?
- yes no dk/u Heart defects, heart murmur, rheumatic heart disease?
- yes no dk/u Angina, arteriosclerosis, stroke or heart attack?
- yes no dk/u Skin disorder (other than common acne)?
- yes no dk/u Does your child eat a well-balanced diet?
- yes no dk/u Frequent headaches or migraines?
- yes no dk/u Frequent ear infections, colds, throat infections?
- yes no dk/u Asthma, sinus problems, hayfever?
- yes no dk/u Tonsil or adenoid condition?
- yes no dk/u Does your child frequently breathe through his/her mouth?
- yes no dk/u Has your child ever taken intravenous bisphosphonates such as Zometa (zoledronic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?
- yes no dk/u Has your child ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel (risedronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone Disorders?

Have you had allergies or reactions to any of the following:

- yes no dk/u Local anesthetics (Novocain, lidocaine, xylocain)
- yes no dk/u Latex (gloves, balloons)
- yes no dk/u Aspirin
- yes no dk/u Ibuprofen (Motrin, Advil)
- yes no dk/u Penicillin
- yes no dk/u Other antibiotics
- yes no dk/u Metal (jewelry, clothing snaps)
- yes no dk/u Acrylics
- yes no dk/u Plant pollens
- yes no dk/u Animals
- yes no dk/u Foods
- yes no dk/u Other substances _____

DENTAL HISTORY

- yes no dk/u Brush teeth daily?
- yes no dk/u Floss teeth daily?
- yes no dk/u Erupting teeth very early or very late?
- yes no dk/u Baby teeth removed that were not loose?
- yes no dk/u Permanent or extra teeth removed?
- yes no dk/u Supernumerary (extra) or congenitally missing teeth?
- yes no dk/u Chipped or injured primary or permanent teeth?
- yes no dk/u Any sensitive or sore teeth?
- yes no dk/u Jaw fractures, cysts, infections?
- yes no dk/u Any teeth treated with root canals or pulpotomies?
- yes no dk/u "Gum boils," frequent canker sores or cold sores?
- yes no dk/u History of speech problems or speech therapy?
- yes no dk/u Difficulty breathing through nose?
- yes no dk/u Mouth breathing habit or snoring at night?
- yes no dk/u History of speech problems?
- yes no dk/u Frequent oral habits (sucking finger, thumb, etc.)?
- yes no dk/u Teeth causing irritation to lip, cheek or gums?
- yes no dk/u Tooth grinding or clenching?
- yes no dk/u Clicking, locking in jaw joints?
- yes no dk/u Soreness in jaw muscles or face muscles?
- yes no dk/u Been treated for "TMJ" or "TMD" problems?
- yes no dk/u Any broken or missing fillings?
- yes no dk/u Any serious problems with previous dental visits?
- yes no dk/u Been diagnosed with gum disease?



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FAMILY MEDICAL HISTORY

- yes no dk/u Bleeding disorders
- yes no dk/u Diabetes
- yes no dk/u Arthritis
- yes no dk/u Sever allergies
- yes no dk/u Unusual dental problems
- yes no dk/u Jaw size imbalance
- yes no dk/u Other family medical conditions

PATIENT HEALTH INFORMATION

Do you think that any of your child's activities affect his/her face, teeth or jaws? How? _____

List any medication, nutritional supplements, herbal medication or non-prescription medicines, including fluoride supplements that your child takes.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Does the patient currently have (or ever had) a substance abuse problem? _____

Does your child chew or smoke tobacco? _____

Have you noticed any unusual changes in your child's face or jaws? _____

Any other physical problems? _____

RELEASE AND WAIVER

I authorize release of any information regarding my (child's) orthodontic treatment to my dental and/or medical insurance company.

Parent/Guardian Signature _____ Date _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my child's medical or dental health.

Parent/Guardian Signature _____ Date _____