BERNARDO CALDAS
ORTHODONTICS

MEDICAL & DENTAL HISTORY

PATIENTS UNDER AGE 18

PATIENT INFORMATION

Patient name

Date of birth

Preferred name

Sex assigned at birth

Male Female

Preferred pronouns

PARENT / GUARDIAN INFORMATION

Parent / guardian 1 full name | Relationship | Cell phone | Email

Parent / guardian 2 full name | Relationship | Cell phone | Email

Any custody, guardianship, or consent restrictions we should know about? Yes No

If yes, please explain:

MEDICAL INFORMATION

Please answer Yes or No. You only need to add details once at the end of this section.

Is your child currently being treated by a physician or specialist? Yes No

Has your child had a major surgery, hospitalization, or serious injury? Yes No

Does your child take any medications, vitamins, or supplements? Yes No

Does your child have any allergies or medication reactions? Yes No

Does your child need antibiotic premedication before dental treatment? Yes No

Any medical, developmental, behavioral, or sensory condition we should know about? Yes No

If yes to any question above, please provide details:

MEDICAL CONDITIONS

Check any that apply. Leave blank if none.

- Heart or blood pressure condition
- Asthma or breathing condition
- Diabetes, thyroid, or endocrine condition
- Bleeding disorder or anemia
- Seizures or neurologic condition
- Kidney, liver, or immune condition
- Nicotine, vaping, or substance-use concern
- Arthritis, bone, or joint condition
- Cancer, chemotherapy, or radiation history
- Mental health or eating disorder
- Frequent headaches or migraines
- Hepatitis, HIV, TB, or significant infection
- Bisphosphonate or other bone medication use

Other medical information:

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HEALTH CARE PROVIDERS

Physician / pediatrician | Last physical | General dentist | Last dental visit

DENTAL & ORTHODONTIC HISTORY

What brings you in today? Any concerns about your child's teeth, bite, smile, or jaw growth?

Previous orthodontic treatment or consultation? Yes No

Any dental injury, root canal, jaw injury, or major dental treatment? Yes No

Any thumb/finger sucking, tongue thrusting, lip sucking, or nail biting? Yes No

Grinding/clenching, jaw pain, clicking, popping, locking, or trouble opening? Yes No

If yes to any question above, please provide details:

AIRWAY / SLEEP

Simple screening questions. A Yes answer does not mean your child has a sleep disorder.

Does your child snore? Yes No

Does your child mouth-breathe or have trouble breathing through the nose? Yes No

Have you noticed pauses, gasping, or choking during sleep? Yes No

Restless sleep, frequent waking, or daytime tiredness? Yes No

Frequent nasal allergies/congestion or enlarged tonsils/adenoids? Yes No

Has your child had a sleep study or been diagnosed with sleep apnea? Yes No

If yes to any question above, please provide details:

FAMILY / OTHER INFORMATION

Family history of jaw-size imbalance, missing/extra teeth, or unusual dental problems? Yes No

Anything else about your child's health, development, or behavior you would like us to know?

AUTHORIZATION

I certify that the information provided is true and complete to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my child's medical or dental health.

Parent / guardian signature (type full name) | Date