Medical/Dental History --Child

Date: _____ School: _____

Patient's Name: _____ Sex: _____ Age: _____ Birthdate: _____

Prefers to be addressed by: _____ Referred by: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Parent's Email address: _____

Father's Name: _____ Occupation: _____ Work Phone: _____

Father's Employer: _____ Cell Phone: _____ SS#: _____

Mother's Name: _____ Occupation: _____ Work Phone: _____

Mother's Employer: _____ Cell Phone: _____ SS#: _____

Parents' Marital Status: Married Single Divorced Separated Widowed

Siblings: Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

Guardian: _____ Home Phone: _____ Cell Phone: _____

Guardian's employer: _____ Occupation: _____ Work Phone: _____

Person Responsible for Account: Father Mother Other (State Name): _____

SS#: _____ Address: _____ Work Phone: _____

Home Phone: _____ Cell Phone: _____

DENTAL INSURANCE

Primary Policy Holder's Name: _____ DOB: _____ SSN: _____

Dental Insurance Co.: _____ Gr. #: _____ Ortho Coverage: Yes NO

Secondary Insurance Co.: _____ Gr. #: _____ Ortho Coverage: Yes NO

Primary Policy Holder's Name: _____ DOB: _____ SSN: _____

Other Insurance Information: _____

DENTAL HISTORY

Patient's Dentist: _____ Date of Last Visit: _____

1. Have there been any injuries to the face, mouth, or teeth? YES NO
2. Has the patient had or presently have any of the following habits? NO Thumb or finger sucking Lip Biting Snoring Grinding of teeth at night Mouth breathing
3. Has the patient been informed of any missing or extra permanent teeth? YES NO
4. Is the patient aware of sores, lumps, or irritated areas in the mouth? YES NO
5. **Has an orthodontist been consulted previously?** **YES NO**

   Name: _____ Date: _____
6. Has the patient ever been treated for: NO Bad Bite TMJ Periodontal disease

   If so, by whom? _____
7. Does the patient have any speech problems? YES NO
8. Is the patient frightened or anxious about Orthodontic treatment? YES NO
9. Is the patient concerned about the appearance of their teeth? YES NO
10. Is there anything the patient would like to change about his/her smile? YES NO

    If so, what: _____
11. What aspect of dental treatment is the patient most concerned with? Quality Cost Discomfort Time
12. **Reason for consultation:** _____
13. Has there ever been any orthodontic treatment for any other member of the family? YES NO

    Are you satisfied with the results? YES NO

Mother (Dr. _____) Father (Dr. _____) Brothers (Dr. _____) Sisters (Dr. _____)

MEDICAL HISTORY

1. Is the patient's general health good at this time? YES NO
2. What is the name of the patient's physician? _____ Date of last physical: _____
3. Is the patient under the care of a physician at this time? YES NO
   Explain: _____
4. Is the patient taking any medication? YES NO
   Name: _____
5. Is the patient allergic to any medication and/or food, please specify. (Penicillin, Sulfa, peanut butter, etc.) YES NO
   Name: _____
6. Has the patient ever had tonsils and adenoids removed? YES NO
   Age: _____
7. Has the patient ever had a serious illness or been hospitalized? YES NO
   Explain: _____
8. Does the patient have any special problems not listed? YES NO
   Explain: _____
9. Has the patient ever been advised by their physician to take an antibiotic prior to any dental treatments? YES NO
   If yes, antibiotic name and method: _____
10. What is the patient's approximate height? _____ Weight? _____
11. Has the patient shown signs of increased growth recently? YES NO
12. Has the patient reached puberty? YES NO
    Girls-- Started menstruating? YES NO
    Boys-- Voice changed? YES NO
13. Father's present height: _____ Mother's present height: _____
    Older brother's present height: _____ Older sister's present height: _____

DOES THE PATIENT NOW, OR HAVE THEY EVER HAD ANY OF THE FOLLOWING? Circle Yes or No

Y N	Endocarditis	Y N	Respiratory Lung disease	Y N	Glaucoma	**MEMO:**		
Y N	Heart Condition	Y N	High Blood Pressure	Y N	Fainting Spells			
Y N	Heart Pacemaker	Y N	Low Blood Pressure	Y N	Kidney Trouble			
Y N	Heart Angina	Y N	Hepatitis (Type?_____)	Y N	Liver Disease			
Y N	Heart Attack (coronary)	Y N	Tuberculosis	Y N	Psychiatric Treatment			
Y N	Mitral Valve Prolapse	Y N	Venereal Disease	Y N	Drug Addiction			
Y N	Congenital Heart Disease	Y N	Herpes (oral-cold sores)	Y N	Headaches			
Y N	Artificial Heart Valve	Y N	Blood Disorders/Bleeding Problems	Y N	Earaches			
Y N	Heart Surgery; date_____	Y N	Inflammatory Rheumatism	Y N	Jaw Clicking			
Y N	Heart Murmur	Y N	Arthritis	Y N	Allergies			
Y N	Rheumatic Fever	Y N	Ulcers	Y N	Allergies to Metal			
Y N	Prosthetic (artificial) joint	Y N	Stroke	Y N	Jaw Pain			
Y N	X-ray/Radiation (cancer) Therapy	Y N	Anemia	Y N	Tonsillitis			
Y N	AIDS or H.I.V. Positive	Y N	Asthma	Y N	Emotional Problems			
Y N	Diabetes	Y N	Epilepsy	Other: _____				

I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct. THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE INFORMATION NOT DISCLOSED. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signature of Parent or Guardian Date

_____

Signature of Orthodontist Date

_____

NOTES: _____

_____

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Please either print and return to our offices or upload using the "Upload Print Forms" Page on our website.