

Medical/Dental History - Child

Date: ____/____/____ Who may we thank for referring you?: _____

Patient's Name: _____ Sex: M / F Age: _____ Birthdate: ____/____/____

Prefers to be addressed as: _____ School: _____ Grade: _____ Email Address: _____

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

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

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

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

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

Parents' Marital Status: Married Single Divorced Separated Widowed

Contact in case of Emergency: Name: _____ Phone #: _____

Guardian: _____ Phone #: _____ Cell #: _____

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

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

Address: _____ SS #: _____ Phone: _____

Other Children in Family: Name: _____ DOB: ____/____/____

Name: _____ DOB: ____/____/____ Name: _____ DOB: ____/____/____

DENTAL INSURANCE

Primary Insurance Co: _____ Gr. #: _____ Ortho Coverage: Yes No

Insureds Name: _____ SS #: _____ Birthdate: _____

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

Insureds Name: _____ SS #: _____ Birthdate: ____/____/____

Other Insurance Information: _____

DENTAL HISTORY

Patient's Dentist Name: _____ 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? 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: 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 (Chief Concern): _____

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

COMMENTS:

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

DOES THE PATIENT NOW, OR HAVE THEY EVER HAD ANY OF THE FOLLOWING?

YES NO	YES NO	YES NO
<input type="checkbox"/> <input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> <input type="checkbox"/> DIABETES	<input type="checkbox"/> <input type="checkbox"/> ADD
<input type="checkbox"/> <input type="checkbox"/> ENDOCARDITIS	<input type="checkbox"/> <input type="checkbox"/> RESPIRATORY LUNG DISEASE	<input type="checkbox"/> <input type="checkbox"/> KIDNEY TROUBLE
<input type="checkbox"/> <input type="checkbox"/> HEART CONDITION	<input type="checkbox"/> <input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> <input type="checkbox"/> LIVER DISEASE
<input type="checkbox"/> <input type="checkbox"/> HEART PACEMAKER	<input type="checkbox"/> <input type="checkbox"/> LOW BLOOD PRESSURE	<input type="checkbox"/> <input type="checkbox"/> PSYCHIATRIC TREATMENT
<input type="checkbox"/> <input type="checkbox"/> HEART ANGINA	<input type="checkbox"/> <input type="checkbox"/> HEPATITIS (type? _____)	<input type="checkbox"/> <input type="checkbox"/> DRUG ADDICTION
<input type="checkbox"/> <input type="checkbox"/> HEART ATTACK (CORONARY)	<input type="checkbox"/> <input type="checkbox"/> VENEREAL DISEASE	<input type="checkbox"/> <input type="checkbox"/> HEADACHES
<input type="checkbox"/> <input type="checkbox"/> MITRAL VALVE PROLAPSE	<input type="checkbox"/> <input type="checkbox"/> HERPES (ORAL-COLD SORES)	<input type="checkbox"/> <input type="checkbox"/> EARACHES
<input type="checkbox"/> <input type="checkbox"/> CONGENITAL HEART DISEASE	<input type="checkbox"/> <input type="checkbox"/> BLOOD DISORDERS/BLEEDING PROBLEMS	<input type="checkbox"/> <input type="checkbox"/> JAW CLICKING
<input type="checkbox"/> <input type="checkbox"/> ARTIFICIAL HEART VALVE	<input type="checkbox"/> <input type="checkbox"/> INFLAMMATORY RHEUMATISM	<input type="checkbox"/> <input type="checkbox"/> ALLERGIES
<input type="checkbox"/> <input type="checkbox"/> HEART SURGERY: date _____	<input type="checkbox"/> <input type="checkbox"/> ULCERS	<input type="checkbox"/> <input type="checkbox"/> ALLERGIES TO METAL
<input type="checkbox"/> <input type="checkbox"/> HEART MURMUR	<input type="checkbox"/> <input type="checkbox"/> STROKE	<input type="checkbox"/> <input type="checkbox"/> ALLERGIES TO LATEX
<input type="checkbox"/> <input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> <input type="checkbox"/> ANEMIA	<input type="checkbox"/> <input type="checkbox"/> JAW PAIN
<input type="checkbox"/> <input type="checkbox"/> ARTHRITIS / OSTEOPOROSIS / BISPHOSPHONATES	<input type="checkbox"/> <input type="checkbox"/> ASTHMA	<input type="checkbox"/> <input type="checkbox"/> TONSILLITIS
<input type="checkbox"/> <input type="checkbox"/> PROSTHETIC (ARTIFICIAL) JOINT	<input type="checkbox"/> <input type="checkbox"/> EPILEPSY	<input type="checkbox"/> <input type="checkbox"/> EMOTIONAL PROBLEMS
<input type="checkbox"/> <input type="checkbox"/> X-RAY/RADIATION (CANCER) THERAPY	<input type="checkbox"/> <input type="checkbox"/> GLAUCOMA	<input type="checkbox"/> <input type="checkbox"/> OTHER: _____
<input type="checkbox"/> <input type="checkbox"/> AIDS OR H.I.V. POSITIVE	<input type="checkbox"/> <input type="checkbox"/> FAINTING SPELLS	

MEMO:

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. I grant authority to the Doctor and Staff to perform all procedures and treatments in the patient's best interest. I understand that, where appropriate, Credit Bureau reports may be obtained. I authorize the Orthodontist to share pertinent treatment information with collaborating dentists and specialists. I authorize the billing of insurance for treatment procedures when appropriate.

Signature of parent or guardian _____

Signature of Orthodontist _____

Today's Date _____

Update _____ Initial _____

Update _____ Initial _____

Update _____ Initial _____

Update _____ Initial _____

NOTES:
