Medical/Dental History - Child

Referred by _____

Date_____

Patient's Name_____Sex:M/F_____Age_____Birthdate_____

Address_____City_____Zip_____Phone_____

Father's Name_____Occupation_____Work Phone_____

Father's
Employer_____S.S.#_____Cell#_____

Mother's Name_____Occupation_____Work Phone_____

Mother's
Employer_____S.S.#_____Cell#_____

Parents' Marital Status (Please Circle) Married Single Divorced Separated Widowed

Guardian_____Phone#_____Cell#_____

Guardian's Employer_____Occupation_____Work Phone_____

Person Responsible for Account (Please Circle) Father Mother Guardian Other

Other Children in Family

Name_____D.O.B._____

Name_____D.O.B._____Name:_____D.O.B._____

Dental Insurance

Primary Insurance Co._____ Gr. #_____

Insureds Name_____S.S. #_____Birthdate_____

Dental History

Patient's Dentist _____ Date of last visit _____

Yes	No	Have there been any injuries to the face, mouth or teeth?
		Has the patient had or presently have any of the following habits? (Please Circle)
		Thumb or finger sucking
		Lip biting
		Snoring
		Grinding of teeth at night
		Mouth Breathing
Yes	No	Has the patient been informed of any missing or extra permanent teeth?
Yes	No	Is the patient aware of sores, lumps or irritated areas in the mouth?
Yes	No	Has an orthodontist been consulted previously?
		Name_____Date_____
Yes	No	Has the patient ever been treated for: (Please Circle)
		Bad Bite
		TMJ
		Periodontal Disease

If so, by whom? _____
When? _____

Yes No Does the patient have any speech problems?
Yes No Is the patient frightened or anxious about Orthodontic treatment?
Yes No Is the patient concerned about the appearance of their teeth?
Yes No Is there anything the patient would like to change about his/her smile?
If so, what? _____
What aspect of dental treatment is the patient most concerned with? (Please Circle)
Cost
Quality
Discomfort
Time
Reason for consultation (Chief Concern) _____
Yes No Has there ever been any orthodontic treatment for any other member of the family?
Mother Dr. _____
Father Dr. _____
Siblings Dr. _____
Yes No Are they satisfied with the results?

Medical History

Yes No Is the patient's general health good at this time?
What is the name of the family physician? _____
Phone # _____
Yes No Is the patient under the care of a physician at this time?
Explain _____
Yes No Is the patient taking any medication?
Name _____
Yes No Is the patient allergic to any medication? (Penicillin, Sulfa, etc.)
Name _____
Yes No Has the patient ever taken any diet medication? (Fen-Phen)
Yes No Has the patient ever had tonsils and/or adenoids removed?
Age _____
Yes No Has the patient ever had a serious illness or been hospitalized? _____
Explain _____
Yes No Does the patient have any special problems not listed?
Explain _____
Yes No Has the patient ever been advised by their physician to take an antibiotic prior to any dental treatments?
If yes, name and dosage of medication _____
Yes No Does the patient use tobacco? (smoking or chewing gum)
What is the patient's approximate height? _____
Weight? _____
Yes No Has the patient shown signs of increased growth recently?
Yes No Has the patient reached puberty?
How long ago? _____

Does the patient now, or have they ever had any of the following? (Please Circle)

Tuberculosis
Endocarditis
Heart Condition
Heart Pacemaker
Rheumatic Fever
Heart Angina
Heart Attack (Coronary)
Mitral Valve Prolapse
Congenital Heart Disease
Artificial Heart Valve
Heart Surgery

Respiratory Lung Disease
High Blood Pressure
Low Blood Pressure
Hepatitis (type?_____)
Venereal Disease
Herpes (Oral-Cold Sores)
Blood Disorders
Inflammatory Rheumatism
Arthritis
Ulcers
Stroke

ADD
Kidney Trouble
Liver Disease
Psychiatric Treatment
Drug Addiction
Headaches
Earaches
Jaw Clicking
Allergies
Allergies to Metal
Allergies to Latex

Heart Murmur	Anemia	Jaw Pain
Rheumatic Fever	Asthma	Tonsillitis
Prosethetic (Artificial) Joint	Epilepsy	Emotional Problems
Radiation (Cancer) Therapy	Glaucoma	Other_____
AIDS or HIV Positive	Fainting Spells	
Diabetes		

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. I grant authority to the Doctor and Staff to perform all procedures and treatments in my best interest. I authorize the Orthodontist to share treatment information with collaborating dentists and surgeons when appropriate. I authorize the Orthodontist to submit treatment information pertinent to this patient to the Insurance Company for billing purposes only. I understand that, when appropriate, Credit Bureau reports may be obtained.

Signature of Parent or Guardian_____
Signature of Orthodontist_____

Today's
Date_____

Update_____Initial_____
Update_____Initial_____
Update_____Initial_____
Update_____Initial_____

NOTES: