Medical/Dental History - Child

Date: _____ School _____

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

Prefers to be addressed by: _____ Referred by: _____ Grade: _____

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

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

Father's Employer: _____ SS#: _____

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

Mother's Employer: _____ Parents' Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

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

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

Guardian: _____ Home Phone: _____

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

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

Address: _____ Business Phone: _____ Home/Cell Phone: _____

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: _____ 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: ❑ Bad Bite ❑ TMJ ❑ Periodontal Disease
   If so, by whom?: ❑ NO
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?	❑ YES ❑ NO
2.	What is the name of the family physician at this time?	Date of last physical:
3.	Is the patient under the care of a physician at this time? Explain:	❑ YES ❑ NO
4.	Is the patient taking any medication? Name:	❑ YES ❑ NO
5.	Is the patient allergic to any medication? (Penicillin, Sulfa, etc.) Name:	❑ YES ❑ NO
6.	Has the patient ever taken any diet medication? (Fen-Phen)	❑ YES ❑ NO
7.	Has the patient had tonsils and/or adenoids removed? Age:	❑ YES ❑ NO
8.	Has the patient ever had a serious illness or been hospitalized? Explain:	❑ YES ❑ NO
9.	Does the patient have any special problems not listed? Explain:	❑ YES ❑ 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:	❑ YES ❑ NO
11.	What is the patient's approximate height?	Weight?
12.	Has the patient shown signs of increased growth recently?	❑ YES ❑ NO
13.	Has the patient reached puberty? Girls – started menstruating? Boys – voice changed?	❑ YES ❑ NO ❑ YES ❑ NO ❑ YES ❑ NO
14.	Father's present height: _____ Older brother's present height: _____	Mother's present height: _____ Older sisters present height: _____

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

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

Signature of parent or guardian

_____

Signature of Orthodontist

_____

Today's Date _____

Update _____ Initial _____

Update _____ Initial _____

Update _____ Initial _____

Update _____ Initial _____

NOTES:

_____

_____

_____

_____

_____