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CHILD HISTORY

PATIENT INFORMATION/CLINICAL HISTORY (please complete in ink)

Name _____ Age _____ Sex _____ Birthdate ____/____/____
Last First MI

Home address _____ Home ph# _____

City _____ State _____ Zip _____

How long residing at current address? _____ Patient's E-mail address _____

School _____ Grade _____

Best telephone to call **during business hours** _____ Cell phone _____

Patient's Family Dentist _____ Last visit _____

Patient's Family Physician _____

Whom may we thank for referring you to our office? _____

Please describe why you have sought this consultation: _____

Who is responsible for the account? Mother Father Guardian

Mother's Information: Married Divorced Single Guardian Widowed

Name _____ Birthdate ____/____/____
Last First MI

Home address _____ Home ph# _____

City _____ State _____ Zip _____ Cell ph# _____

E-mail address _____ SS# _____

Employer _____ Work ph# _____

Does Mother have Orthodontic Insurance? Yes No How long employed with current employer? _____

Name of Insurance Company _____ State _____

ID# _____ Group, plan or Policy# _____

Father's Information: Married Divorced Single Guardian Widowed

Name _____ Birthdate ____/____/____
Last First MI

Home address _____ Home ph# _____

City _____ State _____ Zip _____ Cell ph# _____

E-mail address _____ SS# _____

Employer _____ Work ph# _____

Does Father have Orthodontic Insurance? Yes No How long employed with current employer? _____

Name of Insurance Company _____ State _____

ID# _____ Group, plan or Policy# _____

If responsible party is other than the patient's parent, please give information:

Name _____ SS# _____ Relationship _____

Address _____ Tel# _____

Does responsible party have Orthodontic Insurance? Yes No

Name of Insurance Company _____ State _____

ID# _____ Group, plan or Policy# _____

MEDICAL HISTORY: Have you had or do you have any of the following?

- | | | | |
|-----------------------------|---------------------------|---|-------------------------|
| Y / N Mitral Valve Prolapse | Y / N Scarlet Fever | Y / N Congenital Heart Defect | Y / N Heart Murmur |
| Y / N Rheumatic Fever | Y / N High Blood Pressure | Y / N Hemophilia | Y / N Blood Disorder |
| Y / N AIDS/HIV Infection | Y / N Hepatitis | Y / N Allergies (latex, nickel, plastic) | Y / N Diabetes |
| Y / N Herpes (Any type) | Y / N ADD/ADHD | Y / N Hearing Impairment | Y / N Artificial joints |
| Y / N Arthritis | Y / N Epilepsy | Y / N Mental Health Problems | Y / N Headaches |
| Y / N Sleep Apnea | Y / N Cancer | | |

Please list any other significant information regarding the patient's medical history:

- Y / N Is the patient currently under a physician's care? If yes, reason _____
- Y / N Is the patient currently taking any medication? If yes, describe _____
- Y / N Is the patient allergic to any medications? (aspirin, penicillin, etc.) If yes, what? _____
- Y / N Have there been any injuries to the face, teeth or mouth? If yes, describe _____
- Y / N Has there been any surgery in the head and neck area? If yes, describe _____
- Y / N Has the patient ever had general anesthesia? When? _____
- Y / N Does the patient need to be pre-medicated before dental work?**

DENTAL HISTORY:

- Y / N Do you brush daily?
- Y / N Do you floss daily?
- Y / N Do any of your teeth hurt? If yes, upper or lower, right or left? _____
- Y / N Have you had any previous orthodontic treatment? If yes, when and with whom _____
- Y / N Have there been any injuries to your mouth or teeth? If yes, describe _____
- Y / N Have you ever fallen or bumped your chin? If yes, describe _____
- Y / N Has your jaw ever popped or clicked? If yes, describe _____
- Y / N Do you clench or grind your teeth? If yes, when? _____
- Y / N Does it hurt to chew? _____
- Y / N Have you experienced any problems with previous dental treatment? _____
- Y / N Do you play a musical instrument? _____

Do you have any of the following habits?

- | | | | |
|---------------------------|----------------------|-------------------|-------------------|
| Y / N Finger/Thumbsucking | Y / N Nail biting | Y / N Ice chewing | Y / N Gum chewing |
| Y / N Lip biting/sucking | Y / N Mouth Breather | | |

GROWTH AND DEVELOPMENT:

- Y / N Girls-Has monthly cycle started yet? If so, when? _____
- Y / N Boys-Has voice changed, yet? If so, when? _____
- Y / N Are there any learning disabilities? If yes, explain _____
- Y / N Are there other children in the family? Names and ages: _____
- Y / N Has any other family member had orthodontic treatment? _____
- Y / N Has any other family member been a patient in this practice? _____

Any further information you can provide concerning your child is greatly appreciated. The more we know about each patient, the more helpful we can be in managing the orthodontic treatment, both at home and in the office. Also, please include special interests and hobbies:

I understand that the above medical and dental information is correct to the best of my knowledge. If there are later changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

Signature of Responsible Adult

Date

Doctor's Signature

Date