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 Phone:

Father's Employer: SS#:

Mother's Name: Occupation: Work 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 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? ❑ Thumb or finger sucking ❑ Lip Biting ❑ Snoring ❑ NO ❑ 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. _____)

2.	Are you under the care of a physician at this time? Explain:	❑ YES ❑ NO
3.	What is the name of your family physician?	Date of last physical:
4.	Are you taking any medication? Name:	❑ YES ❑ NO
5.	Are you allergic to any medication? (Penicillin, Sulfa, etc.) Name:	❑ YES ❑ NO
6.	Have you ever taken any diet medication (Fen-Phen)?	❑ YES ❑ NO
7.	Have you ever had a serious illness or been hospitalized? Explain:	❑ YES ❑ NO
8.	Have you had your tonsils and/or adenoids removed? Age:	❑ YES ❑ NO
9.	Do you have any special problems not listed? Explain:	❑ YES ❑ NO
10.	Have you ever been advised by your physician to take an antibiotic prior to any dental treatments? If yes, antibiotic name and method:	❑ YES ❑ NO Pharmacy:
11.	Do you use tobacco? (smoking or chewing)	❑ YES ❑ NO
12.	What is your approximate height?	Weight?
13.	WOMEN: Are you pregnant or considering pregnancy during the next 2 years? Are you currently taking medication for birth control?	❑ YES ❑ NO Are you nursing? ❑ YES ❑ NO ❑ YES ❑ NO

DO YOU HAVE NOW, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO		YES	NO
TUBERCULOSIS	❑	❑	RESPIRATORY LUNG DISEASE	❑	❑	ADD/ADHD	❑	❑
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	❑	❑	BLOOD TRANSFUSION	❑	❑
AIDS OR H.I.V. POSITIVE	❑	❑	GLAUCOMA	❑	❑	OTHER:_____		
DIABETES	❑	❑	FAINTING SPELLS	❑	❑			

MEMO:

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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 Patient

_____

Signature of Orthodontist

_____

Today's Date _____

Update_____Initial_____

Update_____Initial_____

Update_____Initial_____

Update_____Initial_____

NOTES:

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