Medical/Dental History - Child

Date: ____/ ____/_____ Referred by: _____

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

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

Address: City: State: Zip: Phone:

Fathers Name: Occupation: Work Phone:

Father's Employer: SS#: Cell #:

Mothers Name: Occupation: Work Phone:

Mother's Employer: SS#: Cell #:

Parents' Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Guardian: Phone #: Cell #:

Guardian's Employer: Occupation: Work Phone:

Person Responsible for Account: ❑ Father ❑ Mother ❑ Guardian ❑ Other:

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: Date of Last Vislt:

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 an 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?	❑ Yes ❑ 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:	❑ 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 had tonsils and/or adenoids removed? Age:	❑ Yes ❑ No
7.	Has the patient ever had a serious illness or been hospitalized? Explain:	❑ Yes ❑ No
8.	Does the patient have any special problems not listed? Explain:	❑ Yes ❑ No
9.	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
10.	What is the patient's approximate height?	Weight?
11.	Has the patient shown signs of increased growth recently?	❑ Yes ❑ No
12.	Has the patient reached puberty? Girls - started menstruating? Boys - voice changed?	❑ Yes ❑ No ❑ Yes ❑ No ❑ Yes ❑ No
13.	Father's present height: _____ Mother's present height: _____ Older brother'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	
❑	❑	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	❑	❑	ALLERGIES TO LATEX
❑	❑	RHEUMATIC FEVER	❑	❑	ANEMIA	❑	❑	JAW PAIN
❑	❑	PROSTHETIC (ARTIFICIAL) JOINT	❑	❑	ASTHMA	❑	❑	TONSILLITIS
❑	❑	X-RAY/RADIATION (CANCER) THERAPY	❑	❑	EPILEPSY	❑	❑	EMOTIONAL PROBLEMS
❑	❑	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 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:

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