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:

Father's Name: Occupation: Work Phone:

Address:

Father's Employer: Cell#:

Mother's Name:

Address: Occupation: Work Phone:

Mother's Employer Cell#:

Parent's Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Guardian: Phone #: Cell#:

Guardian's Employer: Occupation: Work Phone:

Person Responsible for Account: ☐ Father ☐ Mother ☐ Guardian ☐ Other (State Name:)

Address: SS#: Phone:

Other Children in Family: Name: DOB:

Name: DOB: Name: DOB:

DENTAL INSURANCE

Primary Insurance Co.: Gr.#: Ortho Coverage: ☐ Yes ☐ No

Address for Ins.: ID# or SS#: Birthdate: / /

Secondary Insurance Co.: Gr.#: Ortho Coverage: ☐ Yes ☐ No

Address for Ins.: ID# or 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?

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 his/her teeth? ☐ Yes ☐ No

10. Is there anything the patient would like to change about his/her smile? ☐ Yes ☐ No
If so, what:

11. Reason for consultation (Chief Concern):

12. Has there ever been any orthodontic treatment for any other member of the family? ☐ Yes ☐ No

Mother (Dr._____) Father (Dr._____) Brother (Dr._____) Sister (Dr._____)

MEDICAL HISTORY

		CIRCLE ONE		COMMENTS:
1.	Is the patient's general health good at this time?	Yes	No	
2.	What is the name of the patient's 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 taking hormone replacement, calcium replacement, bisphophonates or osteoporosis treatment medications? Explain:	Yes	No	
6.	Is the patient allergic to any medication? (Penicillin, Sulfa, etc.) Name:	Yes	No	
7.	Has the patient ever taken any diet medication? (Fen-Phen)	Yes	No	
8.	Has the patient ever had tonsils and/or adenoids removed? Age:	Yes	No	
9.	Has the patient ever had a serious illness or been hospitalized? Explain:	Yes	No	
10.	Does the patient have any special problems not listed? Explain:	Yes	No	
11.	Has the patient ever been advised by your physician to take an antibiotic prior to any dental treatments? If yes, antibiotic name and method:	Yes	No	
12.	Does the patient use tobacco? (smoking or chewing)	Yes	No	
13.	What is the patient's approximate height?			
14.	Has the patient shown signs of increased growth recently?	Yes	No	
15.	Has the patient reached puberty? Girls - started menstruating? Boys - voice changed?	Yes Yes	No No	
16.	Father's Present Height: _____ Older Brother's Present Height: _____	Mother's Present Height: _____ Older Sister's Present Height: _____		

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

Yes	No		Yes	No		Yes	No	
☐	☐	TUBERCULOSIS	☐	☐	RESPIRATORY LUNG DISEASE	☐	☐	ATTENTION DEFICIT DIS.
☐	☐	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 PROB.	☐	☐	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 my be obtained. I authorize the Orthodontist to share pertinent treatment information with collaborating dentists and surgeons when appropriate. I authorize the Orthodontist to submit treatment Information to the Insurance Company for billing purposes only.

Signature of parent or guardian

_____

Signature of Orthodontist / Treatment Coordinator

_____

Today's Date _____

Update _____ Initial _____

Update _____ Initial _____

Update _____ Initial _____

Update _____ Initial _____

NOTES:

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