

MEDICAL HISTORY - CHILD

Patient's Name _____ Date _____

Patient's Doctor _____ Phone _____

Is your general health good at this time? Yes No

Are you currently under the care of a physician? Yes No

If yes, please explain:

Are you taking any medications, vitamins or other supplements? Yes No

If yes, please list:

Are you allergic to any medication, food or material? (i.e. penicillin, sulfa, latex, etc.) Yes No

If yes, please list:

Have you ever had a serious illness or been hospitalized? Yes No

If yes, please explain:

Have you ever been advised by your physician to take an antibiotic prior to dental treatments? Yes No

Have you had any history of, difficulty with, or diagnosis of any of the following:

- | | | |
|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growth Problems | <input type="checkbox"/> Organ Transplant |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing | <input type="checkbox"/> Pregnancy (teens) |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Heart | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bones/Joints | <input type="checkbox"/> HIV+/AIDS | <input type="checkbox"/> Sickle cell |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Tobacco/Drug use |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Kidney | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> Latex allergy | <input type="checkbox"/> Use of Phen-Fen or
Redux |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Emotional | <input type="checkbox"/> Lung | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Endocrine | <input type="checkbox"/> Mastoiditis | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Mononucleosis | |

Please list any other special problems not found above:

DENTAL HISTORY – CHILD

Patient's Dentist: _____ Phone: _____

Date of last dental visit: _____

Have there been any injuries to your face, mouth or teeth? Yes No
If yes, please explain:

Have you had or do you presently have any of the following habits: thumb or finger sucking, lip biting, snoring, grinding teeth, or mouth breathing? Yes No

Have you been informed of any missing or extra permanent teeth? Yes No

Has an orthodontist been consulted previously? Yes No
Name: _____ Date: _____

Has the patient ever been treated for bad bite, TMJ or periodontal disease? Yes No
If yes, by whom?

Is there anything you would like to change about your smile? Yes No
If yes, please explain:

Please list the main reasons/concerns for today's consultation:

Has anyone else in the family had orthodontics? Yes No

Are you satisfied with the results? Yes No

I, the undersigned, have completed the health questionnaire and certify that the information is true and correct. I realize that it is my responsibility to inform this office of any changes in the patient's medical status. THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING BECAUSE OF INADEQUATE INFORMATION. I grant authority to the Doctor and Staff to perform all procedures and treatments in the patient's best interest.

Parent Signature

Date

New Patient Information

Patient Name: _____
(First) (Last) (Name Called)

Birthday: _____ Email: _____

Home Phone: _____ Alternate Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Sex: M / F SSN: _____ Race: _____

Dentist: _____ Last Visit: _____

Have any medical problems? _____

How did you hear about us? _____

What about your smile would you like to change? _____

List family members that are currently in our practice: _____

Responsible Party Information

*Responsible Party Name: _____
(First) (Last) (Name Called)

*Birthday: _____ Email: _____

Home Phone: _____ Alternate Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Sex: M / F *SSN: _____ Relationship to Patient: _____

Do you have dental insurance that you would like us to verify orthodontic benefits for you? Yes / No

***Information required for verifying insurance benefits.**

*Insurance Company: _____

Group #: _____ *ID #: _____

*Ins. Phone #: _____ Employer: _____

Additional Information: _____