

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: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> 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: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other (State Name): _____		SS#: _____	
Address: _____	Business Phone: _____	Home Phone: _____	

DENTAL INSURANCE

Primary Insurance Co: _____	Gr. #: _____	Ortho Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No
Insureds Name: _____	SS#: _____	Birthdate: _____
Secondary Insurance Co: _____	Gr. #: _____	Ortho Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Has the patient had or presently have any of the following habits?	<input type="checkbox"/> NO <input type="checkbox"/> Thumb or finger sucking <input type="checkbox"/> Lip Biting <input type="checkbox"/> Snoring <input type="checkbox"/> Grinding of teeth at night <input type="checkbox"/> Mouth breathing
3. Has the patient been informed of any missing or extra permanent teeth?	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Is the patient aware of sores, lumps or irritated areas in the mouth?	<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Has an orthodontist been consulted previously?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Name: _____	Date: _____
6. Has the patient ever been treated for: If so, by whom?: _____	<input type="checkbox"/> NO <input type="checkbox"/> Bad Bite <input type="checkbox"/> TMJ <input type="checkbox"/> Periodontal disease
7. Does the patient have any speech problems?	<input type="checkbox"/> YES <input type="checkbox"/> NO
8. Is the patient frightened or anxious about Orthodontic treatment?	<input type="checkbox"/> YES <input type="checkbox"/> NO
9. Is the patient concerned about the appearance of their teeth?	<input type="checkbox"/> YES <input type="checkbox"/> NO
10. Is there anything the patient would like to change about his/her smile? If so, what: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
11. What aspect of dental treatment is the patient most concerned with?	<input type="checkbox"/> Quality <input type="checkbox"/> Cost <input type="checkbox"/> Discomfort <input type="checkbox"/> Time
12. Reason for consultation (Chief Concern): _____	
13. Has there ever been any orthodontic treatment for any other member of the family? Are you satisfied with the results?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO
Mother (Dr. _____) Father (Dr. _____) Brothers (Dr. _____) Sisters (Dr. _____)	

MEDICAL HISTORY

COMMENTS:

1.	Is the patient's general health good at this time	<input type="checkbox"/> YES <input type="checkbox"/> 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: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
4.	Is the patient taking any medication? Name: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
5.	Is the patient allergic to any medication? (Penicillin, Sulfa, etc.) Name: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
6.	Has the patient ever taken any diet medication? (Fen-Phen)	<input type="checkbox"/> YES <input type="checkbox"/> NO
7.	Has the patient had tonsils and/or adenoids removed? Age: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
8.	Has the patient ever had a serious illness or been hospitalized? Explain: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
9.	Does the patient have any special problems not listed? Explain: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
10.	Has the patient ever been advised by their physician to take an antibiotic prior to any dental treatments? If yes, antibiotic name and method: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
11.	What is the patient's approximate height?	Weight? _____
12.	Has the patient shown signs of increased growth recently?	<input type="checkbox"/> YES <input type="checkbox"/> NO
13.	Has the patient reached puberty? Girls – started menstruating? Boys – voice changed?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO
14.	Father's present height: _____ Older brother's present height: _____	Mother'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	
<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY LUNG DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	ADD
<input type="checkbox"/>	<input type="checkbox"/>	ENDOCARDITIS	<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY TROUBLE
<input type="checkbox"/>	<input type="checkbox"/>	HEART CONDITION	<input type="checkbox"/>	<input type="checkbox"/>	LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	LIVER DISEASE
<input type="checkbox"/>	<input type="checkbox"/>	HEART PACEMAKER	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS (type? _____)	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC TREATMENT
<input type="checkbox"/>	<input type="checkbox"/>	HEART ANGINA	<input type="checkbox"/>	<input type="checkbox"/>	VENEREAL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	DRUG ADDICTION
<input type="checkbox"/>	<input type="checkbox"/>	HEART ATTACK (CORONARY)	<input type="checkbox"/>	<input type="checkbox"/>	HERPES (ORAL-COLD SORES)	<input type="checkbox"/>	<input type="checkbox"/>	HEADACHES
<input type="checkbox"/>	<input type="checkbox"/>	MITRAL VALVE PROLAPSE	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD DISORDERS/BLEEDING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	EARACHES
<input type="checkbox"/>	<input type="checkbox"/>	CONGENITAL HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	INFLAMMATORY RHEUMATISM	<input type="checkbox"/>	<input type="checkbox"/>	JAW CLICKING
<input type="checkbox"/>	<input type="checkbox"/>	ARTIFICIAL HEART VALVE	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES
<input type="checkbox"/>	<input type="checkbox"/>	HEART SURGERY; date _____	<input type="checkbox"/>	<input type="checkbox"/>	ULCERS	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES TO METAL
<input type="checkbox"/>	<input type="checkbox"/>	HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	STROKE	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES TO LATEX
<input type="checkbox"/>	<input type="checkbox"/>	RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>	JAW PAIN
<input type="checkbox"/>	<input type="checkbox"/>	PROSTHETIC (ARTIFICIAL) JOINT	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	TONSILLITIS
<input type="checkbox"/>	<input type="checkbox"/>	X-RAY/RADIATION (CANCER) THERAPY	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>	EMOTIONAL PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	AIDS OR H.I.V. POSITIVE	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____
<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	FAINTING SPELLS			

MEMO:

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 surgeons when appropriate.

Signature of parent or guardian _____

Signature of Orthodontist _____

Today's Date _____

Update _____ Initial _____

Update _____ Initial _____

Update _____ Initial _____

Update _____ Initial _____

NOTES:
