CHILD PATIENT INFORMATION AND HEALTH HISTORY

Welcome to our office. Please fill out both sides of form.

Patients Name _____ Age_____ Birthdate_____Sex _____

Address_____

Home Phone _____ Cell Phone (adult) _____

Email (adult)_____School_____ Grade_____

Person(s) responsible for financial matters

Name(s) _____

Address _____

City,State _____

Home Phone _____

Business Phone_____

Place of Employment_____

Social Security Number _____

Name(s) _____

Address _____

City,State _____

Home Phone _____

Business Phone_____

Place of Employment_____

Social Security Number _____

Are you covered by insurance for orthodontic treatment? ❑ No ❑ Yes

If yes, by which company? _____

	Family Dentist	Family Physician	Referred By
Name	_____	_____	_____
Address	_____	_____	_____
City, State	_____	_____	_____

FAMILY AND PATIENT INFORMATION

Father's Name _____Living?_____ Occupation _____

Mother's Name _____Living?_____ Occupation _____

Parents Marital Status _____Patient Living with: M F Both Other _____

Siblings (names & ages) _____

Patient's interests and hobbies _____

Reason for orthodontic consultation?_____

Has anyone in your family had a similar problem? _____

Is patient self-conscious about his/her teeth?_____

Patient's attitude toward orthodontic treatment _____

MEDICAL HISTORY – Has the patient ever had any of the following? (please circle)

AIDS	Bleeding	Emotional Problems	Head or Face Injuries	Oral Ulcer
Allergy	Bone Loss / Disorders	Epilepsy / Seizures	Hepatitis	Previous Surgery
Anemia	Cold Sores	Growth Problems	Herpes	Rheumatic Fever
Arthritis	Diabetes	Hearing Problems	Kidney Disease	Thyroid Problems
Asthma	Endocrine Problems	Heart Condition	Lung Disease	Other (describe below)

Comments_____

_____

Has the patient been under the care of a physician during the past two years, other than for routine examinations? ❑ No ❑ Yes

Condition _____

Date of last medical exam_____

Do you require antibiotic premedication for dental procedures? ❑ No ❑ Yes

Present drugs or medications _____

Birth Defects _____

Patient's Height _____ Patient's Weight _____

RESPIRATORY HISTORY

Do you:

1. Have allergies to: Drugs: _____ Food: _____

Seasonal Grasses: _____ Other: _____

2. Breathe through mouth?	Seldom	Sometimes	Usually
3. Snore when sleeping?	No	Yes	
4. Have frequent colds?	No	Yes	
5. Have frequent "Stuffy Nose"?	No	Yes	
6. Have frequent sore throat or tonsillitis?	No	Yes	
7. Have chewing or swallowing difficulty?	No	Yes	

Have you received medical treatment from an allergist or ear, nose and throat specialist? ❑ No ❑ Yes

If yes: When _____ By Whom _____

Nasal Surgery _____ Tonsils removed _____ Adenoids removed _____

DENTAL AND TEMPOROMANDIBULAR JOINT HISTORY

Has the patient had any unusual dental experiences? ❑ No ❑ Yes

Any injuries to the mouth, teeth or face? ❑ No ❑ Yes

Specify _____

Date of last dental checkup_____Were the patient's teeth cleaned? ❑ No ❑ Yes

Has the patient had an orthodontic consult or treatment? ❑ No ❑ Yes

Does the patient have Headaches?____ Neck Pain?____ Jaw Pain?____ Ear Pain?____ Face Pain?____ Eye Pain?____ Other?____

Which side hurts? Right_____ Left_____ Both_____

How long have you had these symptoms? _____ years _____ days _____ months

Is the pain constant?_____ aching?____ shooting?____ burning?____ stabbing?____ electrical?____ other?____

Worse in the afternoon?____ Worse in the morning?____ Does it hurt to chew?____ Does it hurt to open wide?____

Does the patient's jaw make a popping noise?_____ clicking?____ grinding?____ other?____

Has the patient's jaw ever "locked" or slipped out of place? _____

Does the patient ever clench or grind his/her teeth?_____ During the day?____ During the night?____

Does the patient have problems with his/her ears?_____ Hearing?____ Dizziness?____ other?____

Is it difficult to swallow? _____ Painful? _____

Are the teeth sore or sensitive? _____

INDICATE HABITS, PAST OR PRESENT

Thumb or Finger Sucking_____ Tongue Thrust (reverse swallowing)_____ Lip Biting_____ Nail Biting_____

Poor Speech Habits_____ Other _____

Additional comments _____

_____

_____

Signature_____ Relationship_____ Date _____