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) _____ Name(s) _____

Address _____ Address _____

City,State _____ City,State _____

Home Phone _____ Home Phone _____

Business Phone_____ Business Phone_____

Place of Employment _____ Place of Employment _____

Social Security Number _____ 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: 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 check)

☐ 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 _____