CONFIDENTIAL

Medical / Dental History Form (Child)

Date____/____/_____

Patient's Name_____ Birth date___/___/____ Age_____ Sex: M F

Home Address_____City_____Zip Code_____

Home Phone_____Cell Phone_____Responsible Party Email_____

Appointments will be verified by Responsible Party email and optional text messages

Parent/Guardian _____Birth date___/___/____Marital Status: S M D
Relationship to patient _____

Employer_____Business Phone_____

Address (if different from patient) _____

Parent/Guardian _____Birth date___/___/____Marital Status: S M D
Relationship to patient _____

Employer_____Business Phone_____

Address (if different from patient) _____

Names and ages of children under 18_____

Does patient have insurance coverage for orthodontic treatment? Yes No

Employee Name_____ID#_____SSN#_____Birthdate___/___/____

Insurance Company_____Employer_____ Group #_____

Employee Name_____ID#_____SSN#_____Birthdate___/___/____

Insurance Company_____Employer_____ Group #: _____

Medical/Dental History
Is patient in good health? Yes No Explain:_____
Is the child physically, mentally, or emotionally impaired? Yes No
Is the patient or has the patient been under the care of a physician for a major illness? Yes No Explain: _____
_____

Has the child had any history of, or conditions related to, any of the following:

___ Anemia	___ Fainting Spells or Dizziness	___ Endocrine Problems	___ Speech Problems
___ Arthritis	___ Hearing or Vision	___ Liver Problems	___ Injury to Mouth/Teeth
___ Asthma	___ Heart	___ Nervous Disorders	___ Injury to Face
___ Bleeding Disorders	___ Hepatitis	___ Seizures	___ Mental Health Disturbance
___ Bones/Joints	___ HIV or AIDS	___ Tobacco/Drug Use	___ Depression
___ Cancer	___ Hyper/Hypotension	___ Thyroid Problems	___ Periodontal/Gum Disease
___ Diabetes	___ Kidney Problems	___ Tuberculosis	___ Other _____

List all drugs or medications now being taken, give reasons: _____
_____
Is premedication (antibiotics) required for dental procedures? Yes No Why?_____
List all allergies or drug sensitivity (including anesthetics, latex and metals)_____

Yes No Has patient ever sucked a thumb or fingers? Until what age?
Yes No Has patient been informed of any missing or extra permanent teeth?
Yes No Has patient ever been told you have TMJ/TMD problems or been treated for TMJ/TMD?
Yes No Has patient ever had any previous orthodontic evaluations or consultations?
What concerns you about your child's teeth:_____

Dentist_____

Referred by_____ Signature _____