



Child History

Today's Date: _____

Child's Name: _____ Nickname: _____
Last First MI

Male Female Child's Birth date: ____/____/____ Child's Age: _____ Home #: _____

Child's Home address: _____

School: _____ Grade: _____

Hobbies/Sports/Activities: _____

Does your child have any brothers and sisters? Yes No (If yes please list ages _____)

Parent's Marital Status: Single Married Divorced Widowed Separated

If divorced who has legal custody? Father Mother

Father's Name: _____ Stepfather Guardian

Home address (if different than patient): _____

Home # (if different than patient): _____ Cell #: _____

Work #: _____ Email: _____

Employer: _____ Occupation: _____

Mother's Name: _____ Stepmother Guardian

Home address (if different than patient): _____

Home # (if different than patient): _____ Cell #: _____

Work #: _____ Email: _____

Employer: _____ Occupation: _____

Orthodontic Insurance

Name of Insurance Co.: _____ Phone #: _____

Subscriber I.D. #: _____ Group #: _____

Subscriber Name: _____ SS# _____ DOB: _____

Secondary Insurance: _____ Phone#: _____

Subscriber I.D. #: _____ Group #: _____

Subscriber Name: _____ SS# _____ DOB: _____

Dental & Medical History

General Dentist _____ Date of Last Cleaning: _____

Whom may we thank for referring you to our office? _____

What are the main concerns that you would like orthodontics to accomplish? _____

Does your child have a fear of dentists? Yes No

Has your child ever been evaluated for or had orthodontic treatment before? Yes No

Has any member of your family had orthodontic treatment? Yes No

Have there been any injuries to the face, mouth, teeth, or chin? Yes No

If yes, please describe: _____

Have adenoids or tonsils been removed? Yes No If yes, when? _____

Does your child need pre-medication prior to dental visits? Yes No

Is your child adopted? Yes No Are they aware of it? Yes No

Has your child ever been diagnosed with any of the following medical problems? (Please check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Clenching/Grinding teeth |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Lip sucking/biting |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mouthbreather |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> HIV+/Aids | <input type="checkbox"/> Nail Biter |
| <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> Kidney/Liver Problems | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic/Scarlet Fever | <input type="checkbox"/> Thumb/Finger Sucking |
| <input type="checkbox"/> Headaches/pain of face & head | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tongue Thrust |

Has your child been diagnosed with any learning disabilities or behavioral disorders that we should be aware of? Please describe: _____

Child's Physician: _____ Phone#: _____

Date of last visit? _____

Please describe your child's current physical health: Good Fair Poor

(If female) Has the patient started to menstruate? Yes No (Age: _____)

Please list all medications your child is currently taking: _____

Please list any medications your child is allergic to: _____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status.

Signature _____ Date _____