SCHMIDT ORTHODONTICS
The Art of a Smile

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: _____City/zip:_____

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): : _____City/zip:_____

Cell #:_____ Would you like text reminders? ☐ Yes ☐ No

Email:_____ Would you like email reminders? ☐ Yes ☐ No

Employer: _____Occupation: _____

Mother's Name: _____ ☐ Stepmother ☐ Guardian

Home address (if different than patient): : _____City/zip:_____

Cell #:_____ Would you like text reminders? ☐ Yes ☐ No

Email:_____ Would you like email reminders? ☐ Yes ☐ No

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)*

____Abnormal bleeding	____Hearing Impairment	____Clenching/Grinding teeth
____ Asthma	____Heart Murmur	____Lip sucking/biting
____ Cancer	____Hepatitis	____Mouthbreather
____ Congenital Heart Defect	____HIV+/Aids	____Nail Biter
____ Convulsions/Epilepsy	____Kidney/Liver Problems	____Speech Problems
____ Diabetes	____Rheumatic/Scarlet Fever	____Thumb/Finger Sucking
____ Headaches/pain of face & head	____Tuberculosis	____Tongue Thrust

Does your child have any special problem, or hospitalizations not listed? Please describe:_____

_____

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

Has the patient reached puberty? ☐ Yes ☐ No (Age:_____)

Please list all medications your child is currently taking: _____

_____

Please list any medications/foods 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 _____