CONFIDENTIAL MEDICAL/DENTAL HISTORY
FOR PATIENTS *UNDER* 18

TELL US ABOUT YOUR CHILD

First Name: ________________________ **MI:** ___ **Last Name:** ________________________________

Nickname: __________________________ Gender: M F

Birth date (mm/dd/yyy): ______________________ Age: __________

Street Address: ____ **Apt/Unit #:** ___________

City: ______________________________ **State:** _________ **Zip Code:** ___________________

Home Phone #: ______________________ Cell Phone #: ________________________

School: ____ Grade: _______

General Dentist: ____ Date of Last Exam: ___________________

WHO IS ACCOMPANYING THE CHILD TODAY?

First Name: __________________ Last Name: _________________________ Relation: _____________

Whom may we thank for referring you to our office?: ____

Other siblings seen by us: ____

PARENT/GUARDIAN INFORMATION

Mother's First Name: _______________________ **Last Name:** _______________________________________

Address: ____ **Phone #:** ____________________
(If different from above)

Father's First Name: _______________________ **Last Name:** _______________________________________

Address: ____ **Phone #:** ____________________
(If different from above)

Who should be contacted for appointments and scheduling?:________________ Email: ____________________________

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT:______________ Email: ____________________________

Relative or Neighbor not living with you

His/Her Name: ____ Relation: ___________________

Phone #: __________________________________

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE INFORMATION

Policy Holder's Name: ________________________

Date of Birth: ________________________________

Social Sec. #:_________________________________

Relationship to Patient: ________________________

Employer: ___________________________________

Work Phone: _________________________________

Insurance Company: __________________________

ID #: _________________ Group #: _____________

Address: _____________________________________

Phone # on Ins. Card: __________________________

SECONDARY DENTAL INSURANCE INFORMATION

Policy Holder's Name: ________________________

Date of Birth: ________________________________

Social Sec. #:_________________________________

Relationship to Patient: ________________________

Employer: ___________________________________

Work Phone: _________________________________

Insurance Company: __________________________

ID #: _________________ Group #: _____________

Address: _____________________________________

Phone # on Ins. Card: __________________________

MEDICAL HISTORY

Your answers are for office records only and are confidential. A thorough medical and dental history is essential to a complete orthodontic evaluation.

Child's Physician: ____________________ Phone #: ______________ Date of last visit: _______________

Describe child's current physical health: □ Good □ Fair □ Poor Are Immunizations Current? □Yes □No

List all drugs that the child is currently taking: ____

List all drugs and/or other things the child is allergic to: ____

Would you like to discuss anything with the doctor in private? □Yes □No

Has the child had/experienced any of the following? Please check those that apply:

□ Abnormal Bleeding
□ Diabetes
□ Low Blood Pressure
□ AIDS/HIV+
□ Epilepsy
□ Lupus
□ Handicaps/Disabilities
□ Measles
□ Anemia
□ Hearing Impairment
□ Mitral Valve Prolapse

□ Any Hospital Stays/Operations
□ Heart Murmur
□ Mononucleosis
□ Asthma
□ Hemophilia
□ Rheumatic Fever
□ Blood Transfusion
□ Hepatitis
□ Scarlet Fever
□ Cancer
□ High Blood Pressure

□ Sickle Cell Anemia
□ Chicken Pox
□ Hives
□ Skin Rash
□ Congenital Heart Defect
□ Kidney Problems
□ Tonsillitis
□ Convulsions
□ Liver Problems
□ Tuberculosis (TB)
□ Other: ________________
____

DENTAL HISTORY

1. What concerns you most about your child's teeth? ______________________________

2. Does your child have any current dental problems? ______________________________

3. Has your child ever had orthodontic treatment? □Yes □No

   If yes, please explain: ______________________________

4. Has anyone in your family received orthodontic treatment? □Yes □No

   If yes, who? ______________________________

5. Does your child feel nervous about having dental treatment? □Yes □No

   If yes, what is his/her biggest concern? ______________________________

6. Has your child ever had an upsetting dental experience? □Yes □No

   If yes, please describe: ______________________________

7. Does your child brush his/her teeth daily? □ Yes □ No

   If no, please describe why: ______________________________

Please answer the following:

- ♦ Is your child presently in any dental pain? □Yes □No
- ♦ Is your child's teeth sensitive? □Yes □No
- ♦ Do your child's gums bleed or hurt? □Yes □No
- ♦ Allergy to Latex? □Yes □No
- ♦ Does your child clench or grind his/her teeth? □Yes □No
- ♦ Does your child have a clicking or popping in his/her jaw? □Yes □No

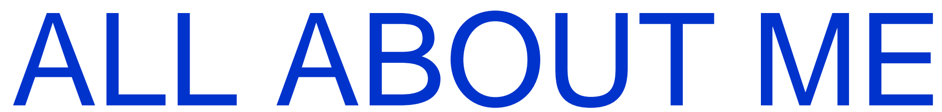
Does/did the child have any of the following habits? Please check those that apply:

□Tongue Thrust
□Mouth Breather
□Thumb/Finger Sucking
□Chewing on Objects
□Nail Biting
□Tongue/Cheek Biting
□Clenching/Grinding Teeth
□ Used Pacifier
□ Breast Fed
□ Lip Sucking/Biting
□Speech Problems
□Nursing Bottle Habits

I have read the above questions and understand them. To the best of my knowledge, all of the preceding answers and information are true and correct. I will not hold the orthodontist and any member of the staff responsible for any errors or omissions that I have made in the completion of this form. I will notify the orthodontist of any changes in my medical and dental health and insurance information if applicable.

______________________________ Date: ______________________________

Signature of parent or guardian



ALL ABOUT ME

NAME: ______________________________

1. What do you want to be when you grow up? ______________________

2. What are some of your hobbies? ________________________________

3. What kind of music do you like? _______________________

4. If you could have any animal in the world as a pet, what would it be? _______________

5. What is your favorite school subject? ______________________

6. If you could have a super power, what would you choose? _________________

7. What is your favorite sport or game? ______________

8. Where is your favorite place in the world? ________________

9. What makes you smile? ____________________________

10. Favorite thing to do with Dad? ____________________________

11. Favorite thing to do with Mom? ____________________________

12. Favorite ice cream flavor? __________________________

13. Favorite food? _________________________________

14. What three words best describe you? ____________________________