CHILD MEDICAL/DENTAL HISTORY

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

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Has your child ever been evaluated or had orthodontic treatment before?

[] Yes [] No

Has patient seen an orthodontist? If so who and when?

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Have there been any injuries to the face, mouth, teeth, or chin?

[] Yes [] No

List any musical instruments played:

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Have adenoids or tonsils been removed?

[] Yes [] No

Does your child snore?

[] Yes [] No

Has your child been informed of any missing or extra permanent teeth?

[] Yes [] No

Has your child ever had any pain/tenderness in jaw joint? (TMJ/TMD)

[] Yes [] No

Does your child brush his/her teeth daily?

[] Yes [] No

Floss his/her teeth daily?

[] Yes [] No

Who is your child's primary dentist?:______________________

When was your child's last cleaning?:______________________

Is your child currently under the care of a physician?

[] Yes [] No

Child's Physician:_________________________________

Phone:_____________ Date of last visit:_______________

Has Puberty Begun?

[] Yes [] No

Has menstruation begun? (Female patients)

[] Yes [] No

Is there a family history of under or overbites?

[] Yes [] No

Height of Parents

Mother:_______________ Father:_______________

Please describe your child's current physical health:

[] Good [] Fair [] Poor

Please list all medications that your child is currently taking:

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Please list all drugs that your child is allergic to:

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Patient's reaction to orthodontic treatment:

[] Excited [] Nervous [] Complacent [] Dreading

Are you aware that your child will have some scheduled appointments during school hours?

[] Yes [] No

Has your child ever had any of the following medical problems?

Bone Disorder	Y. N.
Allergic to Latex/Metals	Y. N.
Congenital Heart Defect	Y. N.
Convulsions/ Epilepsy	Y. N.
Abnormal Bleeding	Y. N.
Hearing Impairment	Y. N.
Kidney/Liver Problems	Y. N.
Handicap/ Disabilities	Y. N.
Allergies to any Drugs	Y. N.
Cleft Lip or Palate	Y. N.
Nutritional Problems	Y. N.
Fainting or Dizziness	Y. N.
Any Dental Pain	Y. N.
Emotional Problems	Y. N.
Autism	Y. N.
Special Needs	Y. N.
Need to Medicate Before Clinical Procedure	Y. N.

Please discuss any medical or dental problems that your child has/had:________________________________

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Has your child ever experienced any unfavorable reaction to dentistry, resulting in dental phobia? If so explain in further detail.

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Does your child have any of the following?

Thumb sucking	Y. N.
Lip Sucking/biting	Y. N.
Clenching/ Grinding Teeth	Y. N.
Nursing Bottle Habits	Y. N.
Mouth Breather	Y. N.
Speech Problems	Y. N.
Nail Biting	Y. N.
Tongue Thrust	Y. N.

Any other questions or concerns:

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

I also authorize the orthodontic staff to perform the necessary dental services my child may need.

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Signature of Parent of Guardian

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.