



## 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            |

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 \_\_\_\_\_