Child' Name _____ Nickname _____
Date of Birth _____ Sex ____Male ____Female Age ____
Reason for this appointment _____

DENTAL HISTORY

(Please circle the appropriate answer)

Any previous orthodontic treatment? NO YES
Any baby teeth or permanent teeth removed by a dentist? NO YES
Any major falls or accidents involving the head, face or teeth? NO YES
Any difficulty breathing through the nose awake or asleep? NO YES
Any clenching of teeth or grinding teeth at night? NO YES
Have other members of your family had orthodontic treatment? NO YES
Does anyone else in your family have similar dental problems? NO YES
Number of brothers _____ Ages ( ) ( ) ( ) ( ) ( )
Number of sisters _____ Ages ( ) ( ) ( ) ( ) ( )
Child's Dentist _____ Date teeth last cleaned _____

HEALTH HISTORY

(Please circle if you have or had any of the following)

Tonsils and/or adenoids removed? NO YES Rheumatic fever? NO YES
Allergies (Including Medications)? NO YES Diabetes? NO YES
Heart Murmur? NO YES
Environmental allergies (such as dogs, cats, trees, etc.)? NO YES
if yes, explain _____
Any Drugs or **NSAIDS** (Advil, Motrin) taken regularly? NO YES
Any other health problems? NO YES If yes, explain _____
Any behavior problems NO YES
Is your child mentally alert? NO YES
Has your child tested positive for HIV or Hepatitis? NO YES
Does your child have ADD, FASD, or any other problems? NO YES
Is your child currently takin Ritalin, Prozac, or others? NO YES
If yes, what is the dosage and how many times a day? _____
If female, has menstruation began? NO YES If yes, at what age? _____
Is your child in good health now? NO YES
Has your child ever had a serious illness or injury? NO YES If yes, explain _____
Child's Physician? _____
Name of School that the child attending _____ Grade attending _____
Does the child play an instrument? NO YES If yes, explain _____
How did you hear about our office? _____

GENERAL INFORMATION

Cell phone _____

Child's residence _____ Home phone _____

Please give the address and home phone for both parents even if they are divorced or separated.

Mother's Name _____ Father's Name _____

Home Address _____ Home Address _____

_____ _____

Home Phone _____ Home Phone _____

Email _____ Email _____

Birthdate _____ Birthdate _____

Social Security No. _____ Social Security No. _____

Place of Employment _____ Place of Employment _____

Position _____ Phone _____ Position _____ Phone _____

Dental Insurance _____ Dental Insurance _____

Orthodontic Coverage NO YES Amount _____ Orthodontic Coverage NO YES Amount _____

Are there special arrangements regarding billing of these procedures? _____

_____

Please provide information regarding additional insurance coverage provided, such as step parents, etc.
I understand that the information that I have given on the Dental and Medical history for and the information given to the Doctor are correct and complete to the best of my knowledge, and that it is my responsibility to inform the Doctor of any change in my child's medical or dental status.

Date _____ Signature _____