Orthodontics
Child Health History

Dental History

Dentist _____ Date of last dental examination _____

Have there been any injuries to the face, mouth or teeth? ◯ Yes ◯ No

Has the patient ever sucked a thumb or fingers? If yes, until what age? _____ ◯ No

Is the patient a mouth breather? ◯ Yes, while awake. ◯ Yes, while asleep. ◯ No

Does the patient grind his/her teeth? ◯ Yes, while awake. ◯ Yes, while asleep. ◯ No

Does the patient have a speech problem? ◯ Yes ◯ No

Does the patient play a musical instrument? ◯ Yes _____ ◯ No

How often does the patient brush his/her teeth? ◯ Several times a day ◯ Twice a day ◯ Once a day ◯ Occasionally ◯ Never

Have you been informed of any missing or extra permanent teeth? ◯ Yes ◯ No

Has any member of the family had orthodontic treatment? ◯ Yes _____ ◯ No

Medical History

Physician _____

Does the patient have any history of major illness? ◯ Yes _____ ◯ No

Has the patient ever been under the care of a physician for illness? ◯ Yes ◯ No

If yes, please explain. _____

Place a check beside the medical conditions which the patient has now or had previously.

◯ AIDS/HIV	◯ Cancer	◯ Hearing Problems	◯ Nervous disorders
◯ Anemia	◯ Cerebral Palsy	◯ Heart disorders	◯ Pneumonia
◯ Arthritis	◯ Glaucoma	◯ Heart murmur	◯ Rheumatic Fever
◯ Asthma	◯ Cold sores/oral ulcers	◯ Hepatitis	◯ Sleep Apnea
◯ Autism	◯ Diabetes	◯ High blood pressure	◯ Thyroid
◯ Bleeding disorders	◯ Endocrine disorders	◯ Kidney disease	◯ Tuberculosis
◯ Bone disorders	◯ Epilepsy	◯ Lung disorders	◯ Other _____

Please comment on any checked above. _____

Does the patient have a tendency to: ◯ colds ◯ sore throats ◯ ear infections

Have the patient's tonsils and/or adenoids been removed? ◯ Yes, age _____ ◯ No

Does the patient have any allergies or drug sensitivities? ◯ Yes _____ ◯ No

Does the patient have a nickel allergy? ◯ Yes ◯ No

Please list all medications the patient is presently taking: _____

Have you ever been told antibiotics are needed before having dental work performed? ◯ Yes ◯ No

Growth & Development

Patient's height _____ Patient's weight _____ Has the patient reached puberty? ◯ Yes ◯ No

{Girls} Has she started menstruation? ◯ Yes ◯ No

{Boys} Has his voice changed or is facial hair growth present? ◯ Yes ◯ No

Check one of the following which best describes his/her progress in school:

◯ Behind children of the same age ◯ Same level as children of the same age ◯ Advanced beyond children of the same age

What is the patient's best subject in school? _____

Hobbies/interests/sports _____

Authorization & Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or health practitioners. I agree to be responsible for payment of all services. I understand that when necessary credit information may be obtained.

Parent/Guardian Signature _____