Medical and Dental History for Patients under 18 years

Your Child

Child's Name ____________________

Nickname ____________ Sex ______

Birthdate ____________ Age ______

SS# / SIN ____________________

School ____________ Grade ______

Child's Home Address ____________________

City ____________ State/Prov. ______ Zip/P.C. ______

Phone ____________________

Responsible Party

Name ____________________

Relationship ____________________

Address ____________________

City ____________ State/Prov. ______ Zip/P.C. ______

Email ____________________

Phone ____________ SS#/SIN ____________

DL# ____________________

Who is responsible for making appointments?

Name ____________________

Home Phone ____________ Cell Phone ____________

Work Phone ____________ Ext. ______

Best time to call ____________________

Time ____________ Day ____________

Mother

☐ Stepmother ☐ Guardian

Name ____________________

Home Phone ____________ Cell Phone ____________

Work Phone ____________ Ext. ______

Email ____________________

Employer ____________________

Occupation ____________________

SS#/SIN ____________ D.O.B. ____________

DL # ____________________

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Father

☐ Stepfather ☐ Guardian

Name ____________________

Home Phone ____________ Cell Phone ____________

Work Phone ____________ Ext. ______

Email ____________________

Employer ____________________

Occupation ____________________

SS#/SIN ____________ D.O.B. ____________

DL # ____________________

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Primary Insurance

Insured's Name ____________________

Relationship ____________________

Birthdate ____________ SS#/SIN ____________

Employer ____________ Date Employed ____________

Occupation ____________________

Insurance Company ____________________

Group # ____________ Employee # ____________

Ins. Co. address ____________________

City ____________ State/Prov. ______ Zip/P.C. ______

Medical Insurance

Insured's Name ____________________

Relationship ____________________

Birthdate ____________ SS#/SIN ____________

Employer ____________ Date Employed ____________

Occupation ____________________

Insurance Company ____________________

Group # ____________ Employee # ____________

Ins. Co. address ____________________

City ____________ State/Prov. ______ Zip/P.C. ______

Dental History *Confidential*

How often does the child brush? ____________________

Is your child's water fluoridated? ☐ Yes ☐ No

Does your child:

- Suck thumb/finger ☐ Yes ☐ No
- Suck/Bite lip ☐ Yes ☐ No
- Bite/Chew nails ☐ Yes ☐ No
- Chew hard objects (pencils, etc.) ☐ Yes ☐ No

How often does your child floss? ____________________

Does the child take fluoride supplements? ☐ Yes ☐ No

- Grind teeth ☐ Yes ☐ No
- Clench jaws ☐ Yes ☐ No
- Gag easily ☐ Yes ☐ No
- Tonsils/Adenoids removed ____ age ☐ Yes ☐ No
- Speech Problem ☐ Yes ☐ No

Dentist ____________________ Address ____________________

Date of last dental visit? ____________________ Phone # ____________________

Has the child had difficulty with previous dental visits? ☐ Yes ☐ No

Child's physician ____________________ Address ____________________

Date of last exam? ____________________ Phone # ____________________

Previous Hospitalizations/Surgeries/Serious Illnesses? ____________________ When? ____________

____

General Information

What concerns you about your child's teeth? ______________________

What concerns your child about his/her teeth? ______________________

How does your child feel about orthodontic treatment? ______________________

Who suggested that your child might need orthodontic treatment? ______________________

Why did you select our office? ______________________

Describe any previous orthodontic treatment or consultations. ______________________

____

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

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

Is the child a mouth breather? while awake ____ while asleep _____ ☐ Yes ☐ No

Has the child ever had any pain/tenderness in their jaw (TMJ/TDM) ☐ Yes ☐ No (explain)

Has the child reached puberty? ☐ Yes ☐ No

Girl - started menstruation? ☐ Yes ☐ No Boy - has his voice changed? ☐ Yes ☐ No

Why did you bring the child to the orthodontist today? ______________________

Is your child currently taking medications? ☐ Yes ☐ No (if yes, please list)

Has your child ever taken FenPhen/Redux? ☐ Yes ☐ No

Does the child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (penicillin, Novocain, etc.)? Yes No (if yes please describe) ______________________

Does the child have a history of allergies to any other substances (latex, environmental, etc.)? ☐ Yes ☐ No

____

____

Medical History

Has the child ever had any of the following:

Asthma.. ☐ Yes ☐ No

Cancer.. ☐ Yes ☐ No

Hepatitis.. ☐ Yes ☐ No

HIV/AIDS... ☐ Yes ☐ No

Hemophilia.. ☐ Yes ☐ No

A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)................ ☐ Yes ☐ No

Abnormal Bleeding................................ ☐ Yes ☐ No

Acid Reflux... ☐ Yes ☐ No

Stomach, liver or kidney problems.................... ☐ Yes ☐ No

Handicaps/Disabilities.. ☐ Yes ☐ No

Tuberculosis.. ☐ Yes ☐ No

Diabetes.. ☐ Yes ☐ No

Rheumatic Fever .... ☐ Yes ☐ No

Congenital Heart Defect...................................... ☐ Yes ☐ No

Heart Murmur.. ☐ Yes ☐ No

Convulsions/Epilepsy.. ☐ Yes ☐ No

Osteoporosis .... ☐ Yes ☐ No

Hearing Impairment... ☐ Yes ☐ No

Handicap/Disabilities... ☐ Yes ☐ No

Please explain any medical problem that your child has: ______________________

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Authorization & Release

I understand that providing incorrect information can be dangerous and it is my responsibility to inform the office of any changes in the child's medical status. I also authorize the staff to perform the necessary services the child may need.

I also authorize the release of any information including the diagnosis and the records of treatment or examination rendered, to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

______________________ ______________________

Signature of patient (or parent/guardian if minor) Date