Child Health History

PATIENT INFORMATION

NAME:

ADDRESS:

CITY: ZIP:

PHONE #:

D.O.B.: AGE: MALE/FEMALE

PARTY RESPONSIBLE FOR ACCT.:

PARENT'S MARITAL STATUS:

REFERRED TO THIS OFFICE BY:

WHAT IS YOUR REASON FOR SEEKING AN ORTHODONTIC EVALUATION?

SPECIAL MEDICAL ALERT - *For office use only*

PARENT OR GUARDIAN INFORMATION

FATHER'S NAME:

ADDRESS:

CITY: ZIP:

PHONE #:

MOTHER'S NAME:

ADDRESS:

CITY: ZIP:

PHONE #:

FATHER'S OCCUPATION:

BUS. ADDRESS:

BUS. PHONE: BUS. FAX: BUS. E-MAIL:

CELL PHONE:

MOTHER'S OCCUPATION:

BUS. ADDRESS:

BUS. PHONE: BUS. FAX: BUS. E-MAIL:

CELL PHONE:

PERSONAL INFORMATION

1. Does your child have any special hobbies or interests? ❒ Yes ❒ No
   Please describe: _____
2. Does your child have brothers and sisters? (list age and sex) _____
3. Has your child been diagnosed as having a learning disability or behavioral disorder? ❒ Yes ❒ No
   Please describe: _____

MEDICAL

PATIENT'S PHYSICIAN NAME: _____

ADDRESS: _____ **PHONE:** _____

Is the patient:

1. Under physicians care? ❒ Yes ❒ No
2. Taking medication? ❒ Yes ❒ No

Does the patient have a history of:

3. Abnormal delivery? ❒ Yes ❒ No
4. Hospitalizations? ❒ Yes ❒ No
5. Rheumatic Fever, Heart Disease, or Heart Murmur? ❒ Yes ❒ No
6. Respiratory problems? ❒ Yes ❒ No
7. Mouth breathing? ❒ Yes ❒ No
8. Prolonged bleeding? ❒ Yes ❒ No
9. Diabetes? ❒ Yes ❒ No
10. Thyroid or Hormone Therapy? ❒ Yes ❒ No
11. Severe headaches? ❒ Yes ❒ No
12. Pains of face or head? ❒ Yes ❒ No
13. Anemia? ❒ Yes ❒ No
14. Epilepsy? ❒ Yes ❒ No
15. Allergies (i.e., aspirin, penicillin, Novocain, etc.)? ❒ Yes ❒ No

    _____

16. Are there any special medical conditions of which we should be aware? ❒ Yes ❒ No

    Please describe: _____

    _____

DENTAL

PATIENT'S DENTIST'S NAME: _____

ADDRESS: _____ **PHONE:** _____

Does the patient:

1. Have a fear of dentists? ❒ Yes ❒ No
2. Receive speech therapy? ❒ Yes ❒ No

Does the patient have a history of:

3. "Cold sores" or acutely sore mouth? ❒ Yes ❒ No
4. Thumb or finger habits? ❒ Yes ❒ No
5. Soreness of jaw muscle or jaw joint? ❒ Yes ❒ No
6. Previous orthodontic therapy? ❒ Yes ❒ No

GENETIC

1. Is the patient adopted? ❒ Yes ❒ No
   If yes, is the patient aware of it? ❒ Yes ❒ No
2. Has any family member had orthodontic treatment? ❒ Yes ❒ No

MATURATIONAL

Ht: _____ Wt: _____

1. *(If Female)* Has the patient started to menstruate? (Age:) ❒ Yes ❒ No
2. *(If Male)* Has his voice changed? ❒ Yes ❒ No
3. *(If Male)* Has facial hair appeared? ❒ Yes ❒ No

I give permission to release any pertinent information to any involved insurance companies or medical/dental professionals.
To the best of my knowledge, the above statements are true and accurate. I agree to inform this office of any changes in the status of my child's health.

Signature: _____ *Date:* _____