MODEL NO. DATE:

PATIENT INFORMATION – CHILD

Last Name: _____ First: _____Middle Initial: _____

Date of Birth: _____ Age: _____ ❑ Male ❑Female

Address: _____

City: _____ Province: _____ Postal Code: _____ Home Phone: _____

Name of Mother: _____ Work Phone: _____ Occupation: _____

Name of Father: _____ Work Phone: _____ Occupation:_____

Name of Dentist: _____ Name of Physician & Telephone:_____

Person responsible for Account: _____ Dental Insurance Coverage: ❑Yes ❑No

How did you hear about this office? _____

MEDICAL HISTORY

A thorough and complete history is vital to a proper Orthodontic evaluation. All answers are for office records only and will be considered confidential. If you are unsure or don't completely understand the question please circle "dk/u" (don't know/unsure).

Yes	No	dk/u	Has the patient been treated for any **medical condition** within the last year?	Yes	No	dk/u	Diabetes?
				Yes	No	dk/u	Ear, nose or throat problems?
Yes	No	dk/u	Is the patient taking any **medication**?	Yes	No	dk/u	Adverse drug reactions?
Yes	No	dk/u	Has the patient ever been **hospitalized** for an **operation** or **serious illness**?	Yes	No	dk/u	Blood or bleeding disorders
				Yes	No	dk/u	Patient have/had Asthma?
Yes	No	dk/u	Any **Allergies**?	Yes	No	dk/u	Arthritis?
Yes	No	dk/u	Is there a history of **Rheumatic fever**, a **Heart Murmur** or Mitral Valve Prolapse?	Yes	No	dk/u	Any Thyroid Disorder?
				Yes	No	dk/u	Birth defects or hereditary problems?
Yes	No	dk/u	Has the patient ever tested positive or have HIV or AIDS?	Yes	No	dk/u	Does the patient smoke or chew tobacco?
Yes	No	dk/u	Any general health change in last year?	Yes	No	dk/u	For women only, is patient pregnant?
Yes	No	dk/u	Does the patient have epilepsy?	Yes	No	dk/u	Mental health or **behavioral** problems?

If you responded yes to any of the above, please give pertinent details: _____

_____

_____

Continued on other side

DENTAL HISTORY

Yes No dk/u Have there been any injuries to the face, mouth or teeth?

Yes No dk/u Have you been informed of any missing or extra permanent teeth?

Yes No dk/u Has he/she been treated for any jaw joint problem, including surgery?

Yes No dk/u Is he/she a mouth breather?

Yes No dk/u Has he/she ever sucked a thumb or a finger? Until what age?____

Yes No dk/u Does he/she have any speech problems?

Yes No dk/u Does he/she want orthodontic treatment?

Yes No dk/u Does he/she have any jaw or facial muscle pain?

Yes No dk/u Does he/she grind their teeth when they sleep?

Yes No dk/u Does he/she clench their jaw?

Yes No dk/u Does he/she chew gum frequently?

Yes No dk/u Has anyone else in the family had orthodontic treatment?

Yes No dk/u Any relative with similar tooth or jaw relationships?

Yes No dk/u Does he/she visit the Dentist regularly? How often?_____ Last visit?_____

Yes No dk/u Has he/she had previous orthodontic treatment? When?_____By whom?_____

When does the child brush their teeth?_____

List any musical instruments played?_____

List any sports, hobbies or interests?_____

Reason for orthodontic consultation (What is your concern? Why are you here?):_____

_____

Realizing that successful treatment greatly depends upon the patients complete cooperation in following instructions, maintaining oral hygiene, and keeping appointments, are there any restrictions, handicaps, or problems that might be encountered during treatment?_____

_____

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form.

If there are any changes later to this history record or medical/dental status, I will so inform this practice.

_____

Signature of parent or legal guardian Date

_____

Reviewed by Orthodontist Date

MEDICAL HISTORY UPDATES OR CHANGES

_____

_____

_____

_____