

Medical/Dental History - Child

Date ____ / ____ / ____

Referred by: _____

Patient's Name: _____ Sex: M / F Age: _____ Birthdate: ____ / ____ / ____

Prefers to be addressed as: _____ School: _____ Grade: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

Father's Name: _____ Occupation: _____ Work Phone: _____

Address: _____

Father's Employer: _____ Cell #: _____

Mother's Name: _____

Address: _____ Occupation: _____ Work Phone: _____

Mother's Employer: _____ Cell #: _____

Parents' Marital Status: Married Single Divorced Separated Widowed

Guardian: _____ Phone #: _____ Cell #: _____

Guardian's Employer: _____ Occupation: _____ Work Phone: _____

Person Responsible for Account: Father Mother Guardian Other (State Name:)

Address: _____ SS#: _____ Phone: _____

Other Children in Family: Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

DENTAL INSURANCE

Primary Insurance Co.: _____ Gr.#: _____ Ortho Coverage: Yes No

Address for Ins.: _____ ID# or SS#: _____ Birthdate: ____ / ____ / ____

Secondary Insurance Co.: _____ Gr.#: _____ Ortho Coverage: Yes No

Address for Ins.: _____ ID# or SS#: _____ Birthdate: ____ / ____ / ____

Other Insurance Information: _____

DENTAL HISTORY

Patient's Dentist: _____ Date of Last Visit: _____

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

2. Has the patient had or presently have any of the following habits? No Thumb or finger sucking Lip Biting Snoring
 Grinding of teeth at night Mouth Breathing

3. Has the patient been informed of any missing or extra permanent teeth? Yes No

4. Is the patient aware of sores, lumps or irritated areas in the mouth? Yes No

5. Has an orthodontist been consulted previously? Yes No

Name: _____ Date: _____

6. Has the patient ever been treated for: Bad Bite TMJ Periodontal disease
if so, by when?

7. Does the patient have any speech problems? Yes No

8. Is the patient frightened or anxious about orthodontic treatment? Yes No

9. Is the patient concerned about the appearance of their teeth? Yes No

10. Is there anything the patient would like to change about his/her smile? Yes No

If so, what: _____

11. Reason for consultation (Chief Concern): _____

12. Has there ever been any orthodontic treatment for any other member of the family? Yes No

Mother (Dr. _____) Father (Dr. _____) Brother (Dr. _____) Sister (Dr. _____)

