PATIENT INFORMATION & HEALTH HISTORY

TELL US ABOUT YOUR CHILD

Patient Name:_____ Age:_____ Birthdate:_____ Sex:_____

Home Address:_____ Nickname:_____

_____ Home Phone:_____

School:_____ Grade:_____ Hobbies/Sports:_____

	Family Dentist	Family Physician	Referred By
Name:	_____	_____	_____
Address:	_____	_____	_____
Last Appointment:	_____	_____	_____

Family History

	Mother	Father
Name:	_____	_____
Address:	_____	_____
	_____	_____
Home Phone:	_____	_____
Work Phone:	_____	_____
Cell Phone:	_____	_____
Email Address:	_____	_____
Place of Employment:	_____	_____
Social Security Number:	_____	_____

Marital Status of Parents: Married ☐ Divorced ☐ Separated ☐ Not Married ☐

Patient living with: Mother ☐ Father ☐ Other ☐

Other family members seen by us:_____

Siblings (name & age):_____

Is Patient adopted? Yes ☐ No ☐

Person Responsible for Financial Matters

Name:_____

Relationship to Patient:_____ **Social Security Number:**_____

Frequency of dental visits/cleaning_____ _____ **Brushings a day**

Medical History: Has your child ever had:

- ☐ Allergy – Latex_Metal___
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints/Valves
- ☐ Asthma/Difficulty Breathing
- ☐ Birth Defects/Congenital Defects
- ☐ Cancer
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Endocrine Problems
- ☐ Emotional Problems
- ☐ Epilepsy/Seizures
- ☐ Headache/Migraines
- ☐ Heart Condition/Murmur
- ☐ Head or Face Injury
- ☐ Hemophilia/Abnormal Bleeding
- ☐ Hepatitis
- ☐ Herpes
- ☐ HIV Positive
- ☐ Kidney/Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Oral Ulcer
- ☐ Previous Surgery
- ☐ Rheumatic Fever
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Other (describe below)

Comments:_____

Respiratory History - Does the Patient:

Have allergies to:

Drugs:_____ Others:_____

Seasonal grasses:_____ Food:_____

2. Breath through mouth?	Seldom	Sometimes	Usually
3. Snore when sleeping?		No	Yes
4. Have frequent colds?		No	Yes
5. Have frequent "stuffy nose"?		No	Yes
6. Have frequent sore throat or tonsillitis?		No	Yes
7. Have chewing or swallowing difficulties?		No	Yes

Has the patient been under the care of a physician during the past two years, other than for routine examination? No Yes
Condition:_____

Does the Patient require **antibiotic premedication** for dental procedures? No Yes

Present drugs or medications:_____

Has the Patient reached puberty (menstruation, voice change, hair) No Yes How long ago?_____

Has the patient received medical treatment from an allergist or ear, nose, and throat specialist? No Yes
If Yes: When_____ By Whom:_____
Nasal Surgery:_____ Tonsils removed:_____ Adenoids removed:_____

Dental and Tempromandibular Joint History

Has the Patient had any unusual dental experiences? No Yes
Specify:_____

Has the patient ever been treated for TMJ ("Jaw Joint") problems? No Yes

Does the patient have:

1. Difficulty in mouth opening?	No	Yes
2. Pain or clicking of jaw joint?	No	Yes
3. Pain on chewing, yawning, or wide opening?	No	Yes
4. Pain in or about the ears or cheeks?	No	Yes
5. A bite that feels "uncomfortable" or "unusual"?	No	Yes
6. A jaw that "locks", "gets stuck", or "goes out"?	No	Yes
7. Noises in or from the jaw joints?	No	Yes

Habits:

1. Thumb/finger/lip sucking until_____(Age)	No	Yes
2. Grinding or clenching of teeth	No	Yes
3. Tongue thrusting or other functional problem	No	Yes

Has the patient had a previous orthodontic consultation? No Yes Or treatment? No Yes
Date:_____ Doctor:_____ City, State:_____

Why did patient seek orthodontic consultation?_____

What is the primary problem?_____

_____

What is expected from orthodontic treatment?_____

Signature:_____ **Relationship:**_____ **Date:**_____