CHILD HEALTH HISTORY FORM

We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

Patient Information

Name _____ _____ _____ Female / Male
Last First Middle I. Sex

Address _____ _____ _____ _____
Street City State Zip Code

Birth Date _____ Home Phone _____

School _____ Hobbies _____

Siblings/Ages _____

General Dentist _____ Last Visited _____

Who may we thank for referring you to our office? _____

Parent Contact Information

Father

Name _____ _____ _____ M / D / S
Last First Middle I. Marital Status

Address _____ _____ _____ _____
Street City State Zip Code

Birth Date _____ Email _____ Social Security # _____

Cell Phone _____ Work Phone _____

Employer _____

Mother

Name _____ _____ _____ M / D / S
Last First Middle I. Marital Status

Address _____ _____ _____ _____
Street City State Zip Code

Birth Date _____ Email _____ Social Security # _____

Cell Phone _____ Work Phone _____

Employer _____

Medical History

Is the child currently under the care of a physician? ☐ Yes ☐ No If Yes, please explain: _____

Physician _____ Phone _____ Date of Last Visit _____

Address _____

Has puberty begun? ☐ Yes ☐ No Has menstruation (period) begun? ☐ Yes ☐ No

What are the main concerns that you would like orthodontics to accomplish? _____

Has the patient ever been evaluated for orthodontic treatment? ☐ Yes ☐ No

Has the patient's tonsils or adenoids been removed? ☐ Yes ☐ No

Has the patient ever experienced jaw joint pain / discomfort (TMJ/TMD)? ☐ Yes ☐ No

Does the patient have any missing or extra permanent teeth? ☐ Yes ☐ No

Has the patient ever had an injury to (select all that apply): ☐ Teeth ☐ Mouth ☐ Chin

Does the patient have speech problems? ☐ Yes ☐ No If Yes, please explain: _____

Does/Has the patient ever had any of the following habits?	☐ Lip Sucking/Biting	☐ Nail Biting	☐ Prolonged Bottle/Pacifier
☐ Clenching/Grinding teeth	☐ Mouth breather	☐ Tongue Thrusting	☐ Thumb/Finger Sucking

Is the child allergic to any of the following?	List all drugs the patient is currently taking.	List any serious medical conditions.
☐ Aspirin ☐ Erythromycin ☐ Codeine ☐ Penicillin ☐ Tetracycline ☐ Latex ☐ Any Metals/Plastics Other Allergies/Sensitivities:		

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidences and it is my responsibility to inform this office of any changes in my medical status.
I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.
I understand that where appropriate, credit bureau reports may be obtained.

Name of person filling out his form _____ **Date** _____