Child Health History

PATIENT INFORMATION

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

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:* ______