CHILD MEDICAL HISTORY FORM

ABOUT YOUR CHILD

Today's Date ____/____/____ ☐ Male ☐ Female

Child's Name _____
Last First MI

Nickname _____

Birth Date _____ Age _____

School _____ Grade _____

Hobbies/Sports _____

Child's Home # (___) _____

Child's Home Address _____

_____
City State Zip

ACCOMPANYING CHILD TODAY

Name _____ Relation _____

Parent's marital status _____

Do you have legal custody of child? ☐ Yes ☐ No

Whom may we thank for referring you? _____

Other family members seen by us: _____

_____

General Dentist _____

Date of last check-up/cleaning _____

☐ Mother ☐ Step Mother ☐ Guardian

Name _____ Birth Date _____

Work# _____ Home (___) _____

Employer _____

Email _____

How long at current job? _____ Title _____

Do you have dental insurance with orthodontic coverage? ___

☐ Father ☐ Step Father ☐ Guardian

Name _____ Birth Date _____

Work# _____ Home (___) _____

Employer _____

How long at current job? _____ Title _____

Do you have dental insurance with orthodontic coverage? ___

Who will be responsible for making appointments? _____

Who will be responsible for the account? _____

What are your main goals that you would like orthodontics to accomplish? _____

_____

Has your child ever been evaluated or had orthodontic treatment before?	☐ Yes	☐ No
Have there been any injuries to the face, mouth, teeth or chin?	☐ Yes	☐ No
Has your child been informed of any missing or extra permanent teeth?	☐ Yes	☐ No
Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)	☐ Yes	☐ No
Does your child brush his/her teeth daily?	☐ Yes	☐ No
Floss his/her teeth daily?	☐ Yes	☐ No
Has puberty begun?	☐ Yes	☐ No
Has menstruation begun? (Girls)	☐ Yes	☐ No

Child's physician _____

Phone# _____ Date of last visit _____

Is your child currently under the care of a physician? _____

Please describe your child's current physical health:

☐ Good ☐ Fair ☐ Poor

Please list all drugs your child is currently taking: _____

_____

Please list all drugs/things that your child is allergic to: _____

_____

Has your child ever had any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Hearing Impairment
Y	N	Allergies to any Drugs	Y	N	Heart Murmur
Y	N	Allergic to Latex/Metals	Y	N	Hemophilia
Y	N	Allergic to Plastic	Y	N	Hepatitis
Y	N	Asthma	Y	N	HIV+/AIDS
Y	N	Cancer	Y	N	Hospitalization
Y	N	Congenital Heart Defects	Y	N	Kidney/Liver Problems
Y	N	Convulsions/Epilepsy	Y	N	Operations
Y	N	Diabetes	Y	N	Rheumatic/Scarlet Fever
Y	N	Handicap/Disabilities	Y	N	Tuberculosis(TB)

Please describe any medical problems that your child has had:

_____

_____

_____

Does/did your child have any of the following habits?

Y	N	Clenching/Grinding	Y	N	Lip Sucking/Biting
Y	N	Nail Biting	Y	N	Tongue Thrust
Y	N	Mouth Breathing	Y	N	Thumb/Finger Sucking
Y	N	Soda Pop Drinker			

I understand that this information is correct and will be held in confidence and it is my responsibility to inform this office of any changes in medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____
Signature of parent or guardian Date

_____
Reviewed Date