

Dental History

Why are you seeking an orthodontic consultation for your child? _____

Has your child consulted with or been treated by an orthodontist previously? Yes No

Y or N Is there a history of clenching or grinding teeth?

Y or N Is there a history of thumb or finger sucking? Until what age? _____

Y or N Is there a history of head, neck, or face injury? Explain _____

Y or N Does your child have speech problems or a tongue thrust? (circle one)

Y or N Is your child a mouth breather?

Y or N Has your child ever had any TMJ problems or TMJ pain?

Y or N Have adenoids or tonsils been removed?

Y or N Has your child been informed of missing or extra permanent teeth?

Y or N Does your child require antibiotics before dental treatment?

Medical History

Please circle if your child has or had any of the following:

Y or N Arthritis

Y or N ADD/ADHD

Y or N Allergies to Drugs

Y or N Allergy to latex/metals

Y or N Allergic to Plastic

Y or N Any Hospital Stays

Y or N Any Operations

Y or N Artificial Joints/Valves

Y or N Asthma

Y or N Anemia

Y or N Blood transfusion

Y or N Cancer

Y or N Convulsions/Epilepsy

Y or N Congenital Heart Defect

Y or N Diabetes

Y or N Handicaps/Disability

Y or N Hearing Impairment

Y or N Heart Murmur

Y or N Hepatitis

Y or N HIV+ or AIDS

Y or N Kidney Problems

Y or N Herpes/Fever Blisters

Y or N Liver Problems/Jaundice

Y or N Lupus

Y or N Emotional Problems

Y or N Tuberculosis (TB)

Y or N Abnormal Bleeding

Y or N Rheumatic/Scarlet Fever

Y or N Is your child currently under the care of a physician?

Y or N Has puberty begun?

Y or N Has menstruation begun (girls)?

Y or N Has your child ever taken Phen-Fen (also known as Redux or Pondimin)?

Please list all medications that your child is currently taking: _____

Please list all medications, etc. that your child is allergic or sensitive to: _____

Child's Physician _____ Phone # _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services that my child may need during diagnosis and treatment with my informed consent.

Signature of parent or guardian

Date

This office reserves the right to verify credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting agencies.

Signature of parent or guardian

Date

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I verbally reviewed the medical/dental information above with parent/guardian named herein.

Initials _____ Date _____ Comments: _____