

Child Dental History Form

Patient's Last Name _____ First Name _____ Middle Name / Initial _____

Patient's Address _____

City _____ State _____ Zip Code _____

Home Phone No. _____ Date of Birth _____ Age _____ Sex: Male Female

School _____ Grade _____

Father's Last Name _____ First Name _____ Middle Name / Initial _____

Address _____

City _____ State _____ Zip Code _____ Date of Birth _____

Home Phone No. _____ Cell Phone No. _____ Business Phone No. _____

Marital Status: Single Married Separated Divorced Widowed

Occupation _____ Employer _____ Soc. Sec. No. _____

Do you have insurance coverage for orthodontic treatment? Yes No

Dental Insurance Company _____ Address _____ Phone No. _____

Mother's Last Name _____ First Name _____ Middle Name / Initial _____

Address _____

City _____ State _____ Zip Code _____ Date of Birth _____

Home Phone No. _____ Cell Phone No. _____ Business Phone No. _____

Marital Status: Single Married Separated Divorced Widowed

Occupation _____ Employer _____ Soc. Sec. No. _____

Do you have insurance coverage for orthodontic treatment? Yes No

Dental Insurance Company _____ Address _____ Phone No. _____

Names and ages of other family members who could benefit from Orthodontic treatment: _____

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

Name of Patient's Dentist _____ Phone No. _____ Date of last Dental Cleaning _____

MEDICAL HISTORY

For the following questions, mark Yes, No, or Don't Know/Understand (DK/U). Your answers are for our office records only, and will be considered confidential. Answers to these questions are vital to a proper orthodontic evaluation.

Do you have allergies or reactions to any of the following?

Yes No DK/U Local anesthetics (Novocaine or Lidocaine)

Yes No DK/U Penicillin or other antibiotics

Yes No DK/U Metals (jewelry, clothing snaps)

Yes No DK/U Latex (gloves, balloons)

E-mail Address: _____

(Over)

**Are you taking medications, nutrient supplements, herbal medications, or non-prescription medicines?
If yes, please name them.**

Medication _____ Taken for _____

Medication _____ Taken for _____

Have you been treated for any of the following?

- | | | | | | | | |
|------------------------------|-----------------------------|-------------------------------|----------------------------------|------------------------------|-----------------------------|-------------------------------|------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Diabetes, Kidney problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Asthma |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Prolonged bleeding | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Allergies |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Hormonal abnormalities |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Heart disorder or heart murmur | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Nervous disorders |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Joint or heart valve replacement | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Rheumatic fever |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Throat or nose problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Ear problems |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Abnormal blood pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Eye problems, Glaucoma |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | AIDS, HIV infection | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Hepatitis, Jaundice |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Tonsillitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Epilepsy, seizure |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Brain injury or stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK/U | Tuberculosis |

Explanation: _____

WOMEN ONLY:

Yes No DK/U Are you pregnant?

DENTAL HISTORY

Now, or in the past, have you had:

- Yes No DK/U Periodontal "gum problems"?
- Yes No DK/U Have you ever been treated for "TMD" or "TMJ" problems?
- Yes No DK/U Ever had a prior orthodontic examination or treatment?

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or my medical/dental status, I will so inform this practice.

Parent's Signature _____ Date Signed _____

MEDICAL HISTORY UPDATE or CHANGES No Changes

Explain changes _____

Parent's Signature _____ Date _____ Staff Signature _____ Date _____

MEDICAL HISTORY UPDATE or CHANGES No Changes

Explain changes _____

Parent's Signature _____ Date _____ Staff Signature _____ Date _____

MEDICAL HISTORY UPDATE or CHANGES No Changes

Explain changes _____

Parent's Signature _____ Date _____ Staff Signature _____ Date _____

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Parent's Signature _____ Date _____ Staff Signature _____ Date _____