

Medical/Dental History - Child

Date: ___/___/___

Referred by: _____

Patient's Name:	Sex: M / F	Age:	Birthdate: / /
Prefers to be addressed as:	School:	Grade:	Email Address:
Address:	City:	Zip:	Phone:

Father's Name:	Occupation:	Work Phone:
Father's Employer:	SS#:	Cell #:

Mother's Name:	Occupation:	Work Phone:
Mother's Employer:	SS#:	Cell #:

Parents' Marital Status: Married Single Divorced Separated Widowed

Guardian:	Phone #:	Cell #:
Guardian's Employer:	Occupation:	Work Phone:

Person Responsible for Account: Father Mother Guardian Other (State Name): _____

Address:	SS#:	Phone:
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Other Children in Family:	Name:	DOB:
Name:	DOB:	Name:
		DOB:

DENTAL INSURANCE

Primary Insurance Co:	Gr. #:	Ortho Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No
Insureds Name:	SS#:	Birthdate:

Secondary Insurance Co:	Gr. #:	Ortho Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No
Insureds Name:	SS#:	Birthdate:

Other Insurance Information: _____

DENTAL HISTORY

Patient's Dentist:	Date of Last Visit:
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1. Have there been any injuries to the face, mouth or teeth? YES NO
2. Has the patient had or presently have any of the following habits?
 NO Thumb or finger sucking Lip Biting Snoring
 Grinding of teeth at night Mouth breathing
3. Has the patient been informed of any missing or extra permanent teeth? YES NO
4. Is the patient aware of sores, lumps or irritated areas in the mouth? YES NO
5. Has an orthodontist been consulted previously?
 YES NO
 Name: _____ Date: _____
6. Has the patient ever been treated for:
 If so, by whom? NO Bad Bite TMJ Periodontal disease
7. Does the patient have any speech problems? YES NO
8. Is the patient frightened or anxious about Orthodontic treatment? YES NO
9. Is the patient concerned about the appearance of their teeth? YES NO
10. Is there anything the patient would like to change about his/her smile?
 If so, what: _____ YES NO
11. What aspect of dental treatment is the patient most concerned with?
 Quality Cost Discomfort Time
12. Reason for consultation (Chief Concern): _____
13. Has there ever been any orthodontic treatment for any other member of the family?
 Are you satisfied with the results? YES NO
 YES NO
 Mother (Dr. _____) Father (Dr. _____) Brothers (Dr. _____) Sisters (Dr. _____)

