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Orthodontics
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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?

☐ Yes	☐ No	☐ DK/U	Diabetes, Kidney problems	☐ Yes	☐ No	☐ DK/U	Asthma
☐ Yes	☐ No	☐ DK/U	Prolonged bleeding	☐ Yes	☐ No	☐ DK/U	Allergies
☐ Yes	☐ No	☐ DK/U	Arthritis	☐ Yes	☐ No	☐ DK/U	Hormonal abnormalities
☐ Yes	☐ No	☐ DK/U	Heart disorder or heart murmur	☐ Yes	☐ No	☐ DK/U	Nervous disorders
☐ Yes	☐ No	☐ DK/U	Joint or heart valve replacement	☐ Yes	☐ No	☐ DK/U	Rheumatic fever
☐ Yes	☐ No	☐ DK/U	Throat or nose problems	☐ Yes	☐ No	☐ DK/U	Ear problems
☐ Yes	☐ No	☐ DK/U	Abnormal blood pressure	☐ Yes	☐ No	☐ DK/U	Eye problems, Glaucoma
☐ Yes	☐ No	☐ DK/U	AIDS, HIV infection	☐ Yes	☐ No	☐ DK/U	Hepatitis, Jaundice
☐ Yes	☐ No	☐ DK/U	Tonsillitis	☐ Yes	☐ No	☐ DK/U	Epilepsy, seizure
☐ Yes	☐ No	☐ DK/U	Brain injury or stroke	☐ Yes	☐ No	☐ 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 _____

MEDICAL HISTORY UPDATE or CHANGES ☐ **No Changes**

Explain changes _____

_____

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