MEDICAL & DENTAL HISTORY OF CHILD/TEEN

Today's Date: ____________

Patient's Name: ____________

Date of Birth: ____________ Age: ______ Years Months

Male: Female: ______ Is this Patient Adopted? YES NO

Address: Street ____________

City ____________ Zip Code ____________

Home Phone: ( ) ____________ Cell Phone: ( ) ____________

E-Mail Address: ____________

Name of School: ____________ Grade: ____________

Mother's Name: ____________ Employer: ____________

Position: ____________ Work Phone: ( ) ____________

Social Security Number: ____________ Date of Birth: ____________

Father's Name: ____________ Employer: ____________

Position: ____________ Work Phone: ( ) ____________

Social Security Number: ____________ Date of Birth: ____________

Marital Status of Parents: ____________

Person Responsible for Financial Matters:

Address and Phone (if Different from above):

Street ____________

City ____________ Zip Code ____________

Does the Patient have Orthodontic Insurance Coverage? **YES** **NO**

If yes, which company? ____________

Who is the Policyholder? ____________

From whom were you referred so that we may send a thank-you? ____________

If our office needs to contact a parent by phone, at which number is most convenient to reach you?

( ) ____________ ( ) ____________ ( ) ____________

Home Office Other - Please Indicate

Names and Ages of Siblings: ____________

____

DENTAL HIStORY

Family Dentist: ____________

Date of last dental exam: ____________

How many times each day does the patient brush his/her teeth?

Has the patient had any injury or trauma to your face, teeth, or gums? YES NO

If yes, please explain: ____________

____

Has the patient ever had an unfavorable dental experience? YES NO

If yes, please explain: ____________

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Has the patient ever or does he/she currently (please circle if applicable):
Grind Teeth at Night Bite Fingernails Suck Thumb or Finger

If yes, when did he/she discontinue? ____________
Does the patient's home water supply have fluoride? YES NO

MEDICAL HISTORY

Family Physician: ____________
Date of last physical exam: ____________
Is the patient currently taking **ANY** medications? YES NO
If yes, please explains: ____________
Is the patient allergic to any medication? YES NO
If yes, please list: ____________
____

Has the patient ever had any of the following:

____ AIDS or HIV	____ Diabetes
____ Anemia	____ Epilepsy/Seizures
____ Arthritis	____ Hearing Problem
____ Artificial Joint or Valve	Heart Murmur (Medicated?)
____ Asthma	____ YES NO
____ Allergies (Please list) ____________	
____ Cancer	____ Hepatitis
____ Cerebral Palsy	____ Kidney Disease
____ Cold Sores	____ Lung Disease
____ Rheumatic Fever	____ Tuberculosis
____ Venereal Disease	
____ Other (Please specify) ____________	

Has the patient ever taken an antibiotic before a dental procedure? YES NO
If yes, please explain: ____________

Has the patient's adenoids and/or tonsils been removed? YES NO
If yes, at what age? ____________

Patient's current height: ____ ft. ____ in. Patient's current weight: ____________ lbs.
Mother's Height: ____ ft. ____ in. Father's Height: ____ ft. ____ in.

FEMALE PATIENTS ONLY:
Has the patient started her menstruation? YES NO
If yes, at what age? ____________
Is there a possibility that the patient may be pregnant? YES NO

Form Completed By: ____________ Today's Date: ____________
(Relationship)