

CHILD PATIENT INFORMATION

WELCOME TO OUR OFFICE

Date _____
Patient's Name _____ Male _____ Female _____
Full Address _____ City _____ Zip _____
Home Phone _____ D.O.B. _____ Age _____
Dentist _____ Who may we thank for referring you _____

RESPONSIBLE PARTY INFORMATION

Father's Name _____ D.O.B. _____
Full Address _____ City _____ Zip _____
Email Address _____
How long at this address _____ Social Security # _____
Home Phone # _____ Work # _____
Employer _____ Occupation _____ # Yrs. Employed _____
Employer's Address _____ Phone #: _____
Insurance Company _____ Group # _____ Plan _____
Insurance Address _____ Phone # _____

Mother's Name _____ D.O.B. _____
Full Address _____
Email Address _____
How long at this address _____ Social Security # _____
Home Phone # _____ Work # _____
Employer _____ Occupation _____ # yrs. Employed _____
Employer's Address _____ Phone #: _____
Insurance Company _____ Group # _____ Plan _____
Insurance Address _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____
Complete address _____
Phone # _____ Relationship to Patient _____

Signature (Parent's signature, if minor) _____
I understand that where appropriate, credit bureau reports may be obtained.

CC: TC: FO: OB:

CHILD PATIENT HEALTH QUESTIONNAIRE FOR: _____

Please complete both pages of this health questionnaire as fully and completely as possible, writing in any other information you feel would be helpful. Your confidentiality will be respected.

FAMILY MEMBERS THAT HAVE HAD/ OR ARE CURRENTLY IN, ORTHODONTIC TREATMENT:

Father _____ Mother _____ Brother _____ Sister _____
_ Other: _____

NAMES AND AGES OF SIBLINGS:

PATIENT'S CURRENT PHYSICAL HEALTH:

_ Excellent _ Good
_ Fair _ Poor

PATIENT'S CURRENT EMOTIONAL HEALTH:

_ Excellent _ Good
_ Fair _ Poor

KNOWN OR SUSPECTED ALLERGIES:

_ Antibiotics: _____
_ Pain medications: _____
_ Foods: _____
_ Environmental allergies: _____
_ None

_____ PLEASE INITIAL

HAS CHILD REACHED PUBERTY:

_ Yes, approximate date: _____
_ No

PRIMARY BREATHING PATTERN:

_ Mouth _ Nose

DOES THE PATIENT SNORE WHEN SLEEPING?

_ Yes _ No
_ Sometimes: _____

- _ Allergies
 - _ Asthma
 - _ Autoimmune disorders
 - _ Blood disease
 - _ High blood pressure
 - _ Low blood pressure
 - _ Bone disorders
 - _ Cancer
 - _ Diabetes
 - _ Dizziness
 - _ Eating disorders
 - _ Endocrine disorder
 - _ Emotional disorder
 - _ Female disorder
 - _ HIV positive status
 - _ Hepatitis
 - _ Heart disease
 - _ Heart murmur
 - _ Hearing disorder
 - _ Kidney disease
 - _ Rheumatic fever
 - _ Ringing of the ears
 - _ Sleep disturbance
 - _ History of trauma
 - _ Teeth _ Face _ Jaws _ Head
 - _ None of the Above
- _____ PLEASE INITIAL

CURRENT MEDICATIONS:

- _ Anti Depressants
- _ Heart medication
- _ Antibiotics: _____
- _ Appetite Suppressants:
- _ Pain medications: _____
- _ Vitamins
- _ Birth control
- _ Muscle relaxants
- _ Insulin
- _ Other: _____
- _ None

_____ PLEASE INITIAL

CHECK ALL THAT APPLY:

- _ Frequent sore throat/tonsillitis
- _ Speech concerns
- _ Pain in the RIGHT jaw joint
- _ Pain in the LEFT jaw joint
- _ Clicking/popping in RIGHT jaw joint
- _ Clicking/popping in LEFT jaw joint
- _ Current thumb/finger sucking habit
- _ Previous thumb/finger sucking habit

Tongue thrust when swallowing

HAS THE PATIENT HAD A PREVIOUS ORTHODONTIC EXAM/CONSULTATION?

- Yes:
- With Dr. _____
- No

ADDITIONAL SURGICAL, MEDICAL OR DENTAL HISTORY?

Please describe: _____

- Twice per year
- More than twice a year
- Emergencies Only
- Never
- Date of last cleaning _____

HOW DO YOU FEEL ABOUT WEARING BRACES?

- Wants treatment
- Unwilling
- But will cooperate if treatment is needed
- Uncooperative

PHYSICIAN NAME:

DUE TO MEDICAL REASONS, IS PATIENT REQUIRED TO BE PRE-MEDICATED PRIOR TO DENTAL WORK: YES _____ NO _____

Responsible Party Signature Printed Name Date

DOCTOR'S NOTES:

