



What are the main concerns that you would like orthodontics to accomplish? _____

- Has your child ever been evaluated or had orthodontic treatment before? Yes No
- Have there been any injuries to the face, mouth, teeth or chin? Yes No
- List any musical instruments played: _____
- Have adenoids or tonsils been removed? Yes No
- Has your child been informed of any missing or extra permanent teeth? Yes No
- Has your child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? Yes No
- Does your child brush his / her teeth daily? Yes No
- Floss his / her teeth daily? Yes No
- Child's Physician: _____
- Phone #: (____) _____ Date of Last Visit: _____
- Is your child currently under the care of a physician? Yes No
- Has puberty begun? Yes No
- Has menstruation begun? (Girls) Yes No
- Has your child ever taken Phen-Fen? Yes No
(Also known as Redux or Pondimin) If yes, when? _____

Please describe your child's current physical health:
 Good Fair Poor

Please list all drugs that your child is currently taking: _____

Please list all drugs/things that your child is allergic to: _____



Has your child ever had any of the following medical problems?

- | | |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes |
| <input type="checkbox"/> Y <input type="checkbox"/> N ADD / ADHD | <input type="checkbox"/> Y <input type="checkbox"/> N Handicaps / Disabilities |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergies to any Drugs | <input type="checkbox"/> Y <input type="checkbox"/> N Hearing Impairment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergic to Latex / Metals | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergic to Plastic | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any Hospital Stays | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any Operations | <input type="checkbox"/> Y <input type="checkbox"/> N HIV+ / AIDS |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones / Joints / Valves | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic / Scarlet Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease / Traits |
| <input type="checkbox"/> Y <input type="checkbox"/> N Convulsions / Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB) |

Please discuss any medical problems that your child has had:



Does/did your child have any of the following habits?

- | | |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Clenching / Grinding Teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Nursing Bottle Habits |
| <input type="checkbox"/> Y <input type="checkbox"/> N Lip Sucking / Biting | <input type="checkbox"/> Y <input type="checkbox"/> N Speech Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Mouth Breather | <input type="checkbox"/> Y <input type="checkbox"/> N Thumb / Finger Sucking |
| <input type="checkbox"/> Y <input type="checkbox"/> N Nail Biting | <input type="checkbox"/> Y <input type="checkbox"/> N Tongue Thrust |



I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

 Signature of parent or guardian Date

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

 Signature of parent or guardian Date

**The Parent or Guardian who accompanies the child is responsible for payment.
 Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.**

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I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Doctor's Comments: _____ Initials: _____ Date: _____

