CHILD HEALTH HISTORY AND REGISTRATION FORM

Today's Date: ____/______/ 20_____

Patient Information

Childs Last Name: ________________________________ First:_________________________ Middle:_________________

Nickname:_____________________________________ Hobbies / Sports: ____

Sex: ☐ Male ☐ Female Date of Birth:____/____/_____ Social Security Number:____________________________

Home Address:____

City: ____________________________________State: _____________________________Zip Code:__________________

Home Phone Number: (_____)________ _____Email Address:___________________________(appointments are confirmed by email)

School:______________________ List brothers / sisters with age: ____

Who is accompanying your child today?_______________________________________ Relation: ____________________

Person responsible for account/appointments:_________________________________ Relation: ____________________

Parents Marital Status: ☐ Single ☐ Married ☐ Partnered ☐Separated ☐Divorced ☐Widowed

Billing address:____

Home # ______________________________ Work #____________________________Cell #________________________

Who may we thank for referring you?____

Do you have orthodontic coverage with your insurance company? ☐ Yes ☐ No

Dental History

It is important that we know your medical and dental history. These facts have a direct bearing on your dental health. This information is strictly confidential and will NOT be released to anyone without your expressed written consent. Thank you for taking the time to completely fill out this questionnaire.

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

____

General Dentist:____ Last Visit Date: ______________________________

What is the date of your last panorex x-ray, if one has been taken? _______________

	YES	NO
Does you child brush his/ her teeth daily?..	☐	☐
Does your child floss his / her teeth daily?..	☐	☐
Have there been any injuries to the face, mouth, teeth or chin?.....................	☐	☐
Has there been any periodontal (gum) treatment?..	☐	☐
Are there any jaw joint/ TMJ related issues?...	☐	☐
Has your child worn braces or previous orthodontic treatment?..	☐	☐

If you answered yes to any of the above questions, please explain:____

Has your child ever experienced any of the following?

Y N Clenching/ Grinding Teeth
Y N Lip Sucking/ Biting
Y N Thumb / Finger Sucking
Y N Nursing Bottle Habits

Y N Nail Biting
Y N Speech Problems
Y N Tongue Thrust
Y N Mouth Breather

Medical History

	YES	NO
Does you child have any **current health problems**?	☐	☐

If yes, please list:____

Is your child presently under a physician's care?	☐	☐

If yes, what is the reason?____

Family Physician: ______________________________Phone Number: (_____)________________

Has puberty begun?	☐	☐
Has menstruation begun (for girls)?	☐	☐

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

Y N Abnormal Bleeding
Y N ADD / ADHD
Y N Allergies or Hives
Y N Anemia
Y N *Artificial Bones/ Hips/Joints
Y N Artificial Heart Valve
Y N Asthma
Y N Cancer or Chemotherapy
Y N Seizures
Y N Diabetes
Y N Fever Blisters
Y N Heart Murmur/ Congenital Heart Lesion
Y N Hemophilia
Y N Hepatitis A, B, or C
Y N HIV or AIDS
Y N Kidney or liver problems
Y N Rheumatic Fever
Y N Pain in Jaw or Joints

Please list all **medications** your child is currently taking:_______________________________________

Is your child **allergic** to any medications, metals, latex or substances? (If yes please list)________________

Please list any other medical or dental information that was not mentioned above: ____________________

Is there any other information that may be pertinent to your treatment here? ________________________

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

Patient Signature:____**Date**:____/_____/20____

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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: ___________