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:____/____/_____

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?_____

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
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
____History of ____Current

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

Medical History

	YES	NO
Does your 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?_____		
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	Diabetes
Y	N	ADD / ADHD	Y	N	Fever Blisters
Y	N	Allergies or Hives	Y	N	Heart Murmur/ Congenital Heart Lesion
Y	N	Anemia	Y	N	Hemophilia
Y	N	*Artificial Bones/ Hips/Joints	Y	N	Hepatitis A, B, or C
Y	N	Artificial Heart Valve	Y	N	HIV or AIDS
Y	N	Asthma	Y	N	Kidney or liver problems
Y	N	Cancer or Chemotherapy	Y	N	Rheumatic Fever
Y	N	Seizures	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: _____

_____

_____

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