CHILD

Let's Get Acquainted

DATE _____

Welcome! So that we may provide you with the best possible care, please complete ***both sides*** *of this form. All information is completely confidential.*

WHAT IS THE REASON FOR YOUR VISIT TODAY?_____

_____

HAVE YOU EVER HAD AN ORTHODONTIC CONSULTATION? YES ☐ NO ☐ OR TREATMENT? YES ☐ NO ☐

PATIENT'S NAME _____ M / F

NICKNAME _____ AGE _____ BIRTHDATE _____

SCHOOL _____ GRADE _____

PARENTS NAME: FATHER _____ MOTHER _____

PARENTS STATUS: SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ SPOUSE DECEASED ☐

ADDRESS _____

CITY _____ ZIP _____ EMAIL _____
(for appointment confirmation)

HOME/CELL # _____

FATHER'S OCCUPATION _____ MOTHER'S OCCUPATION _____

EMPLOYER _____ EMPLOYER _____

DAYTIME PHONE # _____ DAYTIME PHONE # _____

SIBLINGS? NAME/AGE _____

HAVE ANY OTHER FAMILY MEMBERS BEEN SEEN IN OUR OFFICE? YES ☐ NO ☐

IF SO, NAME/RELATIONSHIP _____

REFERRED TO US BY _____

DENTIST _____

TELEPHONE # _____ Last Cleaning Date: M/Y _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT _____

ADDRESS IF DIFFERENT FROM ABOVE _____

DENTAL INSURANCE INFORMATION

INSURANCE COMPANY _____

PHONE # _____

INSURED'S NAME _____ INSURED'S DATE OF BIRTH ____/____/____

POLICY #/ SOCIAL SECURITY # _____

(SEE BACK SIDE)

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? ..... Yes No

   If yes, for what?_____

   Physician's Name _____ Phone _____

2. Have you taken any medication or drugs during the past two years? ..... Yes No
3. Are you taking any medication, drugs or pills now? ..... Yes No

   If yes, please list name and dosage _____

4. Are you allergic to any medication or substance? ..... Yes No

   If yes, please list _____

5. Have you been a patient in the hospital during the past five years? ..... Yes No
6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious) B (serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

7. Do you premedicate with antibiotics for dental procedures? ..... Yes No
8. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No

   If yes, please list _____

9. **Women.** Are you: Pregnant? Yes, ____Months No Nursing? Yes No Taking birth control pills? Yes No

Are you experiencing:

Clicking or popping of the jaw	Yes	No	Difficulty in chewing	Yes	No
Pain (Joint, ear, side of face)	Yes	No	Headaches, neckaches	Yes	No
Difficulty in opening or closing of the mouth	Yes	No	Sore Muscles (neck, face)	Yes	No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Parent/Guardian Signature _____ Date _____

HISTORY REVIEW