



Child Patient Information

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Patient Information - Child

Child's Name: _____
Last First Middle Initial

Address: _____
Street City/State/Zip

Date of Birth: _____ Age: _____ Male/Female

Home Phone: _____ Hobbies/Sports: _____

School: _____ Grade: _____

Please list any brothers/sisters, with ages: _____

Whom may we thank for referring you? _____
Name Address

Person accompanying patient to Consultation: _____ Relationship: _____

Do you have legal custody of this child? Yes No

Responsible Party Information

Parent/Legal Guardian: _____ Mother Father Grandparent Other _____

Address: _____
Street City/State/Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Occupation: _____ Email Address: _____

Employer: _____ City/State: _____ # Years Employed: _____

Social Security #: _____ Date of Birth: _____

Parent/Legal Guardian: _____ Mother Father Grandparent Other _____

Address: _____
Street City/State/Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Occupation: _____ Email Address: _____

Employer: _____ City/State: _____ # Years Employed: _____

Social Security #: _____ Date of Birth: _____

Dental Insurance Information

Subscriber's Name: _____ Social Security #: _____ Date of Birth: _____

Subscriber's Address: _____
Street City/State/Zip Relationship

Insurance Company: _____ Phone #: _____

Address: _____

Group #: _____ Subscriber ID#: _____ Subscriber's Employer: _____

Do you have dual coverage? Yes No If yes:

Subscriber's Name: _____ Social Security #: _____ Date of Birth: _____

Subscriber's Address: _____
Street City/State/Zip Relationship

Insurance Company: _____ Phone #: _____

Address: _____

Group #: _____ Subscriber ID #: _____ Subscriber's Employer: _____

Medical/Dental History

What is your main concern at this time? _____

General Dentist: _____ Last Visit Date: _____

Y N Has your child been evaluated or had orthodontic treatment before? Where? _____

Y N Has there been any injury to the mouth, face, teeth or chin? Date: _____

Y N Are you aware of any missing teeth or extra permanent teeth? List: _____

Y N Has your child ever had any noise, pain, stiffness, or difficulty opening in the jaw joint? (TMJ/TMD)?

Y N Does your child brush teeth daily?

Y N Floss teeth daily?

Y N Does your child generally breathe through their (circle one) ? Nose Mouth

Y N Does your child have allergies/hay fever? Seasonal Year Round

Y N Have adenoids or tonsils been removed? Date: _____

Y N Is your child in good health?

Y N Any changes on your child's health in the past year? Explain: _____

Y N Is your child under the care of a physician? For what reason: _____

Physician: _____ Last Visit Date: _____

Name

Phone

Specialists seen: _____ Treated for: _____

Name

Phone

Y N Has puberty begun?

Y N Females: Has menstruation begun? Date: _____

Has your child ever had any of the following medical problems? Please circle and explain below.

Y N Abnormal bleeding

Y N Hemophilia/Bleeding disorder

Y N Allergy to metal/latex/plastic

Y N Hepatitis/Jaundice/Liver disease

Y N Allergies (treated with medication)

Y N HIV+/AIDS

Y N Arthritis

Y N Hospitalized for any reason

Y N Asthma (treated with medication)

Y N Kidney/Liver problems

Y N Cancer/Chemo/Radiation therapy

Y N Need to take antibiotics for dental work

Y N Congenital Heart Defect

Y N Rheumatic fever/Scarlet fever

Y N Convulsions/Epilepsy/seizures

Y N Severe/Frequent headaches

Y N Diabetes

Y N Sinus Problems

Y N Disability/Handicap

Y N Speech problems/Speech therapy

Y N Glaucoma

Y N Tuberculosis

Y N Hearing Impairment

Y N Venereal Disease

Y N Heart Murmur

Y N Implants

Y N Females: Pregnant/due date: _____

Explain yes responses: _____

Y N Any medications (over the counter drugs or prescriptions) currently taken? Please list with reason.

Please list all drug allergies: _____

Other disease, condition, or problem not listed here we should know about: _____

For Office Use Only

Signature of Doctor reviewing this history _____ TC Initials: _____

I understand that the information regarding my child that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and I understand it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform any necessary dental services to my child that may be needed during diagnosis and treatment with my informed consent.

Signature of Parent/Legal Guardian

Date

