

CHILD (UNDER 18) PATIENT INFORMATION FORM

DATE OF BIRTH: _____ AGE: _____

PATIENT NAME: _____ GENDER: _____
LAST FIRST MIDDLE INITIAL

ADDRESS: _____ CITY: _____ POSTAL CODE: _____

PARENT'S EMAIL ADDRESS: _____ INCLUDE ME IN THE OFFICE E-MAILING LIST: YES NO

PATIENT'S DENTIST: _____ DENTIST'S PHONE: _____ PHYSICIAN: _____

REFERRED BY: _____

PATIENT LIVES WITH: BOTH PARENTS MOTHER FATHER OTHERFATHER'S NAME: _____ HOME PHONE: _____ CELL PHONE: _____
OCCUPATION: _____ WORK PHONE: _____MOTHER'S NAME: _____ HOME PHONE: _____ CELL PHONE: _____
OCCUPATION: _____ WORK PHONE: _____**MEDICAL HISTORY**CHECK ANY OF THE FOLLOWING THE PATIENT HAS HAD:

PROBLEMS AT BIRTH	<input type="checkbox"/>	KIDNEY DISEASE	<input type="checkbox"/>
HEART MURMUR	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>
HEART COND./DISEASE	<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>
RHEUMATIC FEVER	<input type="checkbox"/>	CANCER	<input type="checkbox"/>
ANEMIA	<input type="checkbox"/>	CEREBRAL PALSY	<input type="checkbox"/>
BONE DISORDERS	<input type="checkbox"/>	SEIZURES/EPILEPSY	<input type="checkbox"/>
PROLONGED BLEEDING	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>
HEPATITIS	<input type="checkbox"/>	CLEFT LIP/PALATE	<input type="checkbox"/>
AIDS OR HIV	<input type="checkbox"/>	TONSILS/ADENOID PROB.	<input type="checkbox"/>
TUBERCULOSIS	<input type="checkbox"/>	SLEEP PROBLEMS	<input type="checkbox"/>
LIVER DISEASE	<input type="checkbox"/>	EMOTIONAL/BEHAVIOR PROBLEMS	<input type="checkbox"/>

	<u>YES</u>	<u>NO</u>
IS THE PATIENT IN GOOD HEALTH?	<input type="checkbox"/>	<input type="checkbox"/>

DOES THE PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS OR OPERATIONS?	<input type="checkbox"/>	<input type="checkbox"/>
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PLEASE LIST: _____
LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN: _____

HAS THE PATIENT EVER BEEN REQUIRED TO TAKE ANTIBIOTICS PRIOR TO RECEIVING DENTAL TREATMENT	<input type="checkbox"/>	<input type="checkbox"/>
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DOES THE PATIENT HAVE A TENDENCY TO:		
COLDS	<input type="checkbox"/>	<input type="checkbox"/>
SORE THROATS	<input type="checkbox"/>	<input type="checkbox"/>
EAR INFECTIONS	<input type="checkbox"/>	<input type="checkbox"/>

HAVE THE TONSILS OR ADNOIDS BEEN REMOVED?	<input type="checkbox"/>	<input type="checkbox"/>
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DOES THE PATIENT HAVE ANY ALLERGIES OR DRUG SENSITIVITIES? PLEASE LIST: _____	<input type="checkbox"/>	<input type="checkbox"/>
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HAS THE PATIENT HAD ANY RAPID GROWTH?	<input type="checkbox"/>	<input type="checkbox"/>
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PATIENTS HEIGHT: _____

MOTHERS HEIGHT: _____

FATHERS HEIGHT: _____

FEMALES: Has Menstruation Begun? **DENTAL HISTORY**CHECK ANY OF THE FOLLOWING THAT THE PATIENT HAS (HAD):

JAW DISCOMFORT	<input type="checkbox"/>	JAW CLICKING	<input type="checkbox"/>
TOOTH GRINDING	<input type="checkbox"/>	JAW LOCKING	<input type="checkbox"/>
TOOTH CLENCHING	<input type="checkbox"/>	SPEECH PROBLEMS	<input type="checkbox"/>

MOUTH BREATHING WHILE AWAKE	<input type="checkbox"/>
MOUTH BREATHING WHILE ASLEEP	<input type="checkbox"/>

	<u>YES</u>	<u>NO</u>
HAVE THERE BEEN ANY INJURIES TO THE FACE MOUTH OR TEETH?	<input type="checkbox"/>	<input type="checkbox"/>
IF SO, DESCRIBE: _____		

HAS THE PATIENT EVER SUCKED A THUMB OR FINGER?	<input type="checkbox"/>	<input type="checkbox"/>
UNTIL WHAT AGE? _____		

HAVE EITHER PARENT OR OTHER CHILDREN HAD ORTHODONTIC TREATMENT?	<input type="checkbox"/>	<input type="checkbox"/>
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WHEN DID THE PATIENT LAST VISIT THE DENTIST? _____		
IS THERE ANY WORK STILL TO BE DONE?	<input type="checkbox"/>	<input type="checkbox"/>
IF YES EXPLAIN: _____		

WHEN DID THE PATIENT'S TEETH ERUPT?			
EARLY	<input type="checkbox"/>	AVERAGE	<input type="checkbox"/>
LATE	<input type="checkbox"/>		
WHY DO YOU THINK YOUR CHILD NEEDS ORTHODONTIC CARE?			

LIST HOBBIES AND INTERESTS i.e. SPORTS, MUSIC, INSTRUMENTS...

RESPONSIBLE FOR ACCOUNT: _____

PARENT SIGNATURE_____
DATE OF EXAM