

# 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

PREFERRED NAME \_\_\_\_\_ 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