

MEDICAL HISTORY

Your child's current physical health is: Excellent Good Fair Poor

Is your child currently under the care of a physician? Yes No

If yes, please explain: _____

Physician's Name: _____

Phone #: (_____) _____ Date of last visit: _____

Is your child taking any prescription or over-the-counter drugs? Yes No

If yes, please list each one: _____

Has puberty begun? Yes No

Has menstruation begun? (Girls only) Yes No

HAS YOUR CHILD HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

(Please circle Y or N individually)

- | | |
|------------------------------------|---------------------------------|
| Y N Abnormal Bleeding | Y N Hemophilia |
| Y N ADD/ADHD | Y N Hepatitis |
| Y N Anemia | Y N HIV+/Aids |
| Y N Artificial Bones/Joints/Valves | Y N Hospitalized for any reason |
| Y N Asthma/Arthritis | Y N Kidney Problems |
| Y N Blood Transfusion | Y N Mitral Valve Prolapse |
| Y N Cancer/Chemotherapy | Y N Psychiatric Problems |
| Y N Congenital Heart Defect | Y N Radiation Treatment |
| Y N Diabetes | Y N Rheumatic/Scarlet Fever |
| Y N Difficulty Breathing | Y N Severe/Frequent Headaches |
| Y N Epilepsy/Seizures/Fainting | Y N Sinus Problems |
| Y N Fever Blisters/Herpes | Y N Tuberculosis (TB) |
| Y N Heart Murmur | Y N Ulcers/Colitis |
| Y N Heart Surgery | |

Please list any serious medical condition(s) that your child has ever had:

IS YOUR CHILD ALLERGIC TO ANY OF THE FOLLOWING?

(Please circle Y or N individually)

- | | | |
|-------------------------|------------------------|------------------|
| Y N Aspirin | Y N Dental Anesthetics | Y N Penicillin |
| Y N Any Metals/Plastics | Y N Erythromycin | Y N Tetracycline |
| Y N Codeine | Y N Latex | Y N Other |

Please list any other drugs/materials that you are allergic to: _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and 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 my child may need.

Signature _____ Date _____

What are the main concerns that you would like orthodontics to correct?

Has your child ever been evaluated or had orthodontic treatment before? Yes No

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? Yes No

Have there been any injuries to his/her (please circle): Face Mouth Teeth Chin

Have adenoids or tonsils been removed? Yes No

Has your child been informed of any missing or extra permanent teeth? Yes No

List any musical instruments played: _____

Does your child brush his/her teeth daily? Yes No

Floss his/her teeth daily? Yes No

HAS YOUR CHILD HAD ANY OF THE FOLLOWING PROBLEMS?

(Please circle Y or N individually)

- | | |
|------------------------------|--------------------------|
| Y N Clenching/Grinding Teeth | Y N Snoring |
| Y N Lip Sucking/Biting | Y N Speech Problems |
| Y N Mouth Breather | Y N Thumb/Finger Sucking |
| Y N Nail Biting | Y N Tongue Thrust |
| Y N Nursing Bottle Habits | |

IN THE EVENT OF AN EMERGENCY, IS THERE SOMEONE WHO LIVES NEAR YOU THAT WE SHOULD CONTACT?

His/Her Name: _____ Relation: _____

Wk #: (_____) _____ Hm #: (_____) _____

The Parent or Guardian who accompanies the child is responsible for payment.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting agencies.

Signature _____ Date _____

If this office accepts my insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible(s) that my insurance does not cover.

Signature _____ Date _____