CHILD'S PATIENT CONFIDENTIAL INFORMATION

Last Name_____First Name_____Initial____Phone #_____
Consultation Date _____Date of Birth_____ Age:_____ Sex: M / F

Address:_____ City:_____ Postal Code:_____
Patient's Dentist: Dr._____ Referred by:_____
Physician:Dr._____ School:_____ Grade_____
Number of children in family_____ Age and Sex_____
Names of other family members treated by us_____

Parent / Guardian Info

Person responsible for account_____ Phone #_____
Address_____
Do you have Orthodontic Insurance?_____Do you have General Dentistry Insurance?_____

Father's Name_____ Employed by_____
Work Phone No. _____ May we contact you there? YES NO _____
Cell No. _____ Email:_____
Mother's Name_____Employed by_____
Work Phone No._____ May we contact you there? YES NO _____
Cell No._____ Email:_____
Are the father & mother: (circle one) *married, separated, divorced, common-law*
Who does the child live with:_____

MEDICAL HISTORY (Circle Yes or No)

Heart trouble ..... yes ..... no
Rheumatic fever..... yes ..... no
Hepatitis.....yes .....no
Anemia.....yes .....no
Headaches.....yes .....no
Eye problems.....yes .....no
Arthritis.....yes .....no

Diabetes..... yes ..... no
Epilepsy..... yes ..... no
Pneumonia.....yes .....no
Prolonged bleeding....yes .....no
Stomach trouble.....yes .....no
Asthma.....yes .....no
Cancer.....yes .....no

AIDS or HIV positive..... yes.....no
Hearing problems..... yes .....no
Ear aches..... yes .....no
Kidney problems..... yes .....no
Fainting & dizziness……yes…...no
Nervous disorders.....yes .....no

Is the patient in good health.....yes .....no
List any medications being taken.....
.....
Do they have a tendency to colds.....yes .....no
sore throats…....yes .....no
ear infections…….yes .....no

Is there any history of major illness.....yes .....no
List any allergies or drug sensitivities.....
.....
Have tonsils and/or adenoids been removed.....yes .....no
Have they reached puberty...Girls (menstruation).....yes .....no
Boys (voice change).....yes .....no

DENTAL HISTORY (Circle Yes or No)

Any injuries to the face, mouth or teeth.....yes .....no
Is the patient a mouth breather -while awake .....yes ....no
-while sleeping....yes ....no
Is there any missing or extra permanent teeth.....yes ....no
Is patient aware of .....Grinding teeth.....yes ....no
Jaw joint noises.....yes ....no
Pain in ear region…….yes.....no
Play any musical instruments.....yes .....no

Has the patient ever sucked a thumb or finger…....yes…… no
Until what age?.....
Does the patient have any speech problems…….....yes .....no
Have any teeth been extracted.....yes .....no
Frequent colds or canker sores…….....yes.....no
Previously seen by an orthodontist.....yes .....no
Does the patient want orthodontic treatment.....yes .....no

When did the patient last have a dental check-up.....
Does he/she play sports? Hobbies?.....
Reason for orthodontic consultation.....

_____ _____ _____
Signature of Parent or Guardian Signature of Orthodontist Date