Child Patient Form

Name: _____ Birthdate: _____ Age: _____ Sex: _____
Home Address: _____ City & Zip: _____
Mailing Address (if different): _____
Siblings' Names: _____
Parent's Marital Status: ☐ Married ☐ Remarried ☐ Divorced ☐ Separated ☐ Single ☐ Widowed

Father's Name: _____ Mother's Name: _____
Employed By: _____ Employed By: _____
Work Phone: _____ Work Phone: _____

Stepfather's Name: _____ Stepmother's Name: _____
Employed By: _____ Employed By: _____
Work Phone: _____ Work Phone: _____

(If applicable)
Guardian: _____ Relationship: _____ Phone: _____

PERSON RESPONSIBLE FOR ACCOUNT IS PARENT BRINGING PATIENT

Dentist: _____ Physician: _____
Referred By: _____ Last Dental Appt.: _____

Medical History

Has the patient been diagnosed with or treated for any of the following conditions?

☐ Diabetes	☐ Tuberculosis	☐ Prolonged bleeding	☐ Endocrine disorders
☐ Epilepsy	☐ Rheumatic fever	☐ Hepatitis	☐ Bone disorders
☐ Polio	☐ Heart murmur	☐ Gastro-intestinal	☐ Fainting/dizziness
☐ Arthritis	☐ Heart condition	☐ Cerebral palsy	☐ Tonsils removed
☐ Asthma	☐ Anemia	☐ Emotional problems	☐ Adenoids removed

YES NO
○ ○ Is patient presently under a physician's care?
For: _____
_____
○ ○ Is patient taking any pills, medications, or drugs?
_____
_____
○ ○ Has patient ever had an unusual reaction to medication? _____
_____
○ ○ Is patient allergic to anything? _____
_____
_____

○ ○ Does patient have a tendency to:
Colds _____
Sore throats _____
Ear infections _____
○ ○ Has patient had any major surgery?
For: _____
○ ○ Does patient have a chronic problem with:
Kidneys _____
Lungs _____
Liver _____
○ ○ Are there any other medical problems not mentioned above? _____
_____

Dental History

YES NO
○ ○ Has patient experienced any unfavorable reaction from any previous dental treatment that you are aware of?
○ ○ Does patient suck thumb or fingers?
○ ○ Does patient breathe predominantly through the mouth?
○ ○ Does patient have any speech problems?
○ ○ Does patient clench or grind teeth?

YES NO
○ ○ Does patient have pain or clicking when closing the mouth?
○ ○ Has patient had any severe head or face injuries?
When? _____
○ ○ Have any teeth been injured or chipped?
When? _____
○ ○ Any noticeable difficulty in chewing or swallowing?
○ ○ Does patient have any extra or missing teeth?

- Have any teeth been removed by extraction? Why? _____
- Has the patient used a retainer or space maintainer?
- Has anyone in the family had orthodontic treatment?
- Has patient had any previous orthodontic consultation or treatment?
- Would patient mind wearing:
  Braces _____
  Headgear _____
- Has patient ever been teased about the appearance of his/her teeth?
- Does the patient want his/her teeth straightened?

I have examined the above information and it is true and correct.

Signature: _____ Date: _____