MEDICAL DENTAL HISTORY- CHILD

Patient's Name:_____ Age:_____ Birth Date: _____

□ Male □ Female Phone Number: _____ Email: _____

Dentist: _____ Phone Number: _____

Date of Last Dental Exam:_____ Reason: _____

Parent(s) or Guardian(s): _____ How did you hear about us?_____

Home Address: _____ City: _____ Zip: _____

School: _____ Musical Instruments Played:_____

Sports And/Or Hobbies: _____

Approximate Height: Mother_____ Father_____ Does patient follow directions well?_____

Does patient brush his/her teeth consistently? _____ Is the patient allergic to latex? _____

History of antibiotic prophylaxis for dental treatment? _____

Please check each box, yes or no, if the patient has ever had any illness or conditions listed below.

Y	N		Y	N		Y	N		Y	N	
□	□	Arthritis	□	□	Allergies	□	□	Anemia	□	□	Artificial Joint
□	□	Asthma	□	□	Cancer	□	□	Diabetes	□	□	Dizzy Spells
□	□	Epilepsy	□	□	Fainting	□	□	Heart Murmur	□	□	Hepatitis
□	□	Kidney Disease	□	□	Liver Problems	□	□	Lung Disease	□	□	Nervous Disorder
□	□	Mental Disorder	□	□	Sinus Trouble	□	□	Stroke	□	□	Tuberculosis
□	□	Supernumerary (extra) teeth				□	□	Jaw fractures, cysts or mouth infections			
□	□	Periodontal "gum problems"				□	□	Pain in jaw or ringing in ears			
□	□	Congenitally missing teeth				□	□	Family history of jaw size imbalance			

Has the patient had any disease, serious illness/surgery, condition or problem not listed above? Y N
If yes, explain_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my orthodontist of any change in my health. I further certify that I consent to the performing of x-rays, oral examination, and pictures taken for office records.

_____ _____
Patient's Signature/Responsible Party Date

For Doctor's Use Only

Health History Reviewed By_____ (Dr Signature) Date:_____
Notes:
_____
_____
_____