CHILDS PATIENT FORM

CONFIDENTIAL INFORMATION

Last Name: ..... First Name: ..... Grade: .....

Consultation Date: ..... Date of Birth: ..... / ..... / ..... Age: ..... Sex: .....

Address: ..... City: ..... Postal Code: ..... Phone # .....

Referred by: ..... Dentist: ..... Physician: .....

Name of other family members treated: .....

.....

PARENT / GUARDIAN INFORMATION

Person Responsible for account: ..... Address (If different than above) : .....

.....

Do you have Orthodontic Insurance? **[ ] YES [ ] NO** Do you have General Dentistry Insurance? **[ ] YES [ ] NO**

Father's Name: .....

Employed by: ..... Occupation: ..... Email: .....

Work Phone #..... Cell Phone # ..... May we contact you there? **[ ] YES [ ] NO**

Mother's Name: .....

Employed by: ..... Occupation: ..... Email: .....

Work Phone #..... Cell Phone # ..... May we contact you there? **[ ] YES [ ] NO**

MEDICAL HISTORY (Indicate YES or NO)

Heart trouble	**[ ] YES [ ] NO**	Diabetes	**[ ] YES [ ] NO**	AIDS or HIV positive	**[ ] YES [ ] NO**
Rheumatic fever	**[ ] YES [ ] NO**	Epilepsy	**[ ] YES [ ] NO**	Hearing problems	**[ ] YES [ ] NO**
Hepatitis	**[ ] YES [ ] NO**	Pneumonia	**[ ] YES [ ] NO**	Ear aches	**[ ] YES [ ] NO**
Anaemia	**[ ] YES [ ] NO**	Prolonged bleeding	**[ ] YES [ ] NO**	Kidney problems	**[ ] YES [ ] NO**
Headaches	**[ ] YES [ ] NO**	Stomach trouble	**[ ] YES [ ] NO**	Fainting & dizziness	**[ ] YES [ ] NO**
Eye problems	**[ ] YES [ ] NO**	Asthma	**[ ] YES [ ] NO**	Nervous disorders	**[ ] YES [ ] NO**
Arthritis	**[ ] YES [ ] NO**	Cancer	**[ ] YES [ ] NO**		

Is the patient in good health **[ ] YES [ ] NO** List any medications being taken: .....

.....

continued...

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MEDICAL HISTORY (Indicate YES or NO) ... cont'd

Is there any history of major illness **[ ] YES [ ] NO** List any allergies or drug sensitivities: .....

.....

Do they have a tendency towards ....colds **[ ] YES [ ] NO** ....sore throats **[ ] YES [ ] NO** ....ear infections **[ ] YES [ ] NO**

Have they reached puberty?

Girls (menstruation) **[ ] YES [ ] NO**

Boys (voice change) **[ ] YES [ ] NO**

Have tonsils and adenoids been removed? **[ ] YES [ ] NO**

DENTAL HISTORY (Indicate YES or NO)

Are you a mouth breather ..... while awake **[ ] YES [ ] NO**

Are you a mouth breather ..... while sleeping **[ ] YES [ ] NO**

Are you aware of ..... grinding teeth **[ ] YES [ ] NO**

Are you aware of ..... jaw joint noise **[ ] YES [ ] NO**

Are you aware of ..... pain in ear region **[ ] YES [ ] NO**

Are there any missing or extra permanent teeth **[ ] YES [ ] NO**

Do you play any musical instruments ..... **[ ] YES [ ] NO**

Any injuries to the face, mouth or teeth **[ ] YES [ ] NO**

Do you 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**

Do you want orthodontic treatment **[ ] YES [ ] NO**

When did the patient last have a dental check-up? .....

Do he/she play sports? Hobbies? .....

Reason for orthodontic consultation .....

.....

....

Signature of Parent or Guardian Signature of Orthodontist Date

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