

Has your child ever had or been evaluated for orthodontic treatment?

No Yes When? _____

Have there been any injuries to the face, mouth, teeth or chin? No Yes When? _____

List any musical instruments played: _____

Have adenoids or tonsils been removed? No Yes

Does your child have any missing or extra permanent teeth? Yes No

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

Explain: _____

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

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

Does your child have any of the following habits?

Y N Thumb/Finger Sucking	Y N Mouth Breather
Y N Lip Sucking/Biting	Y N Speech Problems
Y N Clenching/Grinding	Y N Nail Biting

Medical History

Child's Physician's: _____

Phone #: (_____) _____

Date of last visit: ____/____/____

Reason for visit: _____

Is your child currently under the care of a physician?

Yes No

If yes, please explain: _____

Has puberty begun? Yes No

If a girl, has menstruation begun? Yes No

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

If yes, please list: _____

Is your child allergic to any of the following items?

Y N Penicillin	Y N Tetracycline	Y N Latex
Y N Aspirin	Y N Dental Anesthetics	Y N Any Metal/Plastic
Y N Erythromycin	Y N Codeine	Y N Other

Please list all drugs your child is allergic to:

Does your child have or ever had any of the following diseases or medical problems?

- | | |
|----------------------------|-------------------------------------|
| Y N Heart Murmur | Y N Congenital Heart Defect |
| Y N Cancer | Y N Convulsions/Epilepsy |
| Y N Diabetes | Y N Abnormal Bleeding |
| Y N Rheumatic Fever | Y N Hearing Impairment |
| Y N HIV+/AIDS | Y N Any Operations? |
| Y N Hemophilia | Y N Any stays in a hospital? |
| Y N Asthma | Y N Kidney/Liver Problems |
| Y N Hepatitis | Y N Handicaps/Disabilities |
| Y N Tuberculosis | |

Does your child need premedication for Dental Procedures?

Yes No

I understand that the information that I have given today is correct to the best of my knowledge and this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that my child may need.

Signature _____ Date _____

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 this office, use the services of one or more credit reporting services.

Signature _____ Date _____

**OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA,
THE CENTER FOR DISEASE CONTROL AND THE AMERICAN DENTAL ASSOCIATION**