CHILD HEALTH HISTORY **PATIENT INFORMATION** Date _____

Patient's name_____Nickname_____ Gender: M or F Birth date _____

Address _____ _____
Street City State Zip Phone

School _____Patient's Dentist _____ Whom may we thank for referring you to our office?_____

What do you think is the patient's orthodontic problem? _____

Parents Marital Status: Married____ Separated ____ Divorced ____ Widowed ____ Single ____

FATHER: Name _____ Phone_____ Birth date _____Email Address_____

Address _____
Street City State Zip

Employer_____ Occupation _____ No. Yrs Employed _____Work Phone_____

MOTHER: Name _____ Phone_____ Birth date_____ Email Address_____

Address _____
Street City State Zip

Employer_____ Occupation_____ No. Yrs Employed _____ Work Phone_____

Person Responsible for financial arrangements: _____Relationship_____

Do you have **ORTHODONTIC** Insurance? ___Name of Co.: _____Policy # _____ Group #_____

Emergency INFORMATION: Name of nearest relative **NOT** living with you:_____ Relationship:_____

Complete Address:_____ Phone #_____

MEDICAL HISTORY

Is the patient in good health? ___ yes ___no Explain : _____
Any major or unusual illness? ___ yes ___no Explain: _____
Currently being treated by a physician? ___ yes ___no Explain: _____
Currently taking medication? ___ yes ___no Explain: _____
Drug Allergies? ___ yes ___no Explain: _____

Any premedications prior to dental procedures? _____ If so, list:_____

Physician's Name _____Address:_____Phone_____

Please check if PATIENT HAS OR HAD any of the following:

YES	NO		YES	NO		YES	NO	
___	___	Anemia	___	___	Heart Problems	___	___	Glaucoma
___	___	Blood Disease	___	___	Tuberculosis	___	___	Prolonged Bleeding
___	___	Diabetes	___	___	Adenitis	___	___	Asthma
___	___	Jaundice	___	___	Endocrine Problems	___	___	Tonsils removed: Age _____
___	___	Rheumatic Fever	___	___	Bone Disorders	___	___	Adenoids removed: Age _____
___	___	Scarlet Fever	___	___	Epilepsy	___	___	Mouth breathing: While awake/asleep?
___	___	Hepatis	___	___	Herpes	___	___	Is the patient in a risk group for AIDS?

Name and ages of any brothers and sisters: _____

DENTAL HISTORY

YES	NO	
____	____	Has the patient had any severe head or facial injuries? Explain:_____
____	____	Has the patient had a history of thumb/finger sucking? Stopped? _____ When? _____
____	____	Does the patient play any wind instruments? _____ What? _____
____	____	Has the patient consulted an orthodontist previously? If so, who? _____Any treatment?_____
____	____	Did either parent have orthodontic treatment? _____

Please check if the patient has a history of:

___ Clenching teeth
___ Grinding teeth
___ Muscular soreness around Head &/or Neck
___ Headaches (more than normal)
___ Jaw Joint Soreness
___ Jaw Joint Clicking
___ Jaw Joint Popping
___ Ringing in the Ears

To the best of my knowledge, the above information is correct.
Parent's/Guardian's Signature: _____ **Date** _____

I give my permission for Dr. Jones and his staff to take necessary x-rays, photographs and impressions of the above minor child for diagnostic and educational purposes.
Parent's/Guardian's Signature: _____ **Date** _____