



## Medical Dental Form - CHILD

### Tell us about your Child

Today's date : \_\_\_/\_\_\_/\_\_\_ Male \_\_\_ Female \_\_\_

Childs Name \_\_\_\_\_

Nickname \_\_\_\_\_ SS# \_\_\_\_\_

Childs Birthday \_\_\_/\_\_\_/\_\_\_ Child Age \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Hobbies/Sports \_\_\_\_\_

Child's Home # (\_\_\_\_) \_\_\_\_\_

Child Home Address \_\_\_\_\_

\_\_\_\_\_

### Mother's Information

Name: \_\_\_\_\_

Birth date : \_\_\_/\_\_\_/\_\_\_

Work # (\_\_\_\_) \_\_\_\_\_

Home # (\_\_\_\_) \_\_\_\_\_

Employer How long at current job: \_\_\_\_\_

Job title \_\_\_\_\_

SS # \_\_\_\_\_

DL # \_\_\_\_\_

### Who is accompanying your child today?

Name \_\_\_\_\_ Relation \_\_\_\_\_

Yes \_\_\_ No \_\_\_

Whom may we thank for referring you?

\_\_\_\_\_

List brother and sisters with age:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

General Dentist : \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_

Parental Marital Statues:

Single \_\_\_ Married \_\_\_ Widowed \_\_\_

Divorced \_\_\_\_\_

\_\_\_\_\_

### Father's Information

Name: \_\_\_\_\_

Work # (\_\_\_\_) \_\_\_\_\_

Home # (\_\_\_\_) \_\_\_\_\_

Employer How long at current job: \_\_\_\_\_

Job title \_\_\_\_\_

SS # \_\_\_\_\_

DL # \_\_\_\_\_

### Person Responsibility for Account

Name : \_\_\_\_\_

Billing Address: \_\_\_\_\_

\_\_\_\_\_

Previous Address \_\_\_\_\_

\_\_\_\_\_

Home # (\_\_\_\_) \_\_\_\_\_

DL # \_\_\_\_\_

Employer \_\_\_\_\_

Work # (\_\_\_\_) \_\_\_\_\_ SS # \_\_\_\_\_

### Who is responsible for making appointment?

Name: \_\_\_\_\_

Work # (\_\_\_\_) \_\_\_\_\_ Cel # (\_\_\_\_) \_\_\_\_\_

Home # (\_\_\_\_) \_\_\_\_\_

**Primary Orthodontic Insurance**

Orthodontic Coverage Yes \_\_\_ No \_\_\_  
Insurance Co Name \_\_\_\_\_  
Insurance Co Name \_\_\_\_\_  
Insurance Co Phone # ( \_\_\_ ) \_\_\_\_\_  
Group # \_\_\_\_\_  
Policy Owner's Phone # ( \_\_\_ ) \_\_\_\_\_  
Policy Owner's birth date \_\_\_/\_\_\_/\_\_\_  
Employer \_\_\_\_\_

**What are the main concerns that you would like orthodontics to accomplish?**

\_\_\_\_\_

Has your child ever been evaluated or had orthodontic treatment before Yes \_\_\_ No \_\_\_  
Have there been any injuries to the face, mouth, teeth, chin? Yes \_\_\_ No \_\_\_  
List any musical instruments played:

\_\_\_\_\_

Have adenoids or tonsils been removed? Yes \_\_\_ No \_\_\_  
Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD) Yes \_\_\_ No \_\_\_  
Does your child brush his/her teeth daily? Yes \_\_\_ No \_\_\_  
Does your child floss daily? Yes \_\_\_ No \_\_\_  
Child's Physician: \_\_\_\_\_

Phone ( \_\_\_ ) \_\_\_\_\_ Date of last visit \_\_\_\_\_  
Is your child under the care of physician? Yes \_\_\_ No \_\_\_

Has puberty begun? Yes \_\_\_ No \_\_\_  
Has menstruation begun Mo/year \_\_\_/\_\_\_  
Please describe your child's current physical health  
Good \_\_\_ Fair \_\_\_ Poor \_\_\_  
Please list all medication that your child is currently taking \_\_\_\_\_  
Please list medication that your child is allergic to \_\_\_\_\_

**Has your child ever had of the following medical problems?**

Y N Abnormal bleeding      Y N Diabetes  
Y N Allergies to any dugs      Y N Hemophilia  
Y N Handicap/Disabilities      Y N Hepatitis  
Y N Heart Murmur      Y N HIV + AIDS  
Y N Asthmas      Y N Any Operation  
Y N Allergic to Latex/Metals      Y N Cancer  
Y N Kidney/Liver Problem  
Y N Congenital Heart Defect  
Y N Rheumatic/Scarlet Fever  
Y N Convulsions/Epilepsy  
Y N Tuberculosis

Please discuss any medical problems that your child has had? \_\_\_\_\_  
\_\_\_\_\_

**Does did your child have any of the following habits?**

Y N Clenching teeth  
Y N Lip sucking/Biting  
Y N Mouth Breather  
Y N Thumb/Finger Sucking  
Y N Tongue Thrust  
Y N Nursing Bottle Habits  
Y N Speech Problems  
Y N Nail Biting

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

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date