CHILD PATIENT INFORMATION FORM

Welcome to our office…
Please assist us by completing the following questions:

DATE OF EXAM: _____________
DATE OF BIRTH: _____________

CHILD'S NAME____
Last **First**

AGE__________ SEX________
ADDRESS___________________________CITY_________POSTAL CODE_________
PHONE__________________ EMAIL________________________
CHILD'S DENTIST_______________________________
CHILD'S PHYSICIAN___________________________________
CHILD LIVES WITH: BOTH PARENTS____ MOTHER_____ FATHER_____ ADOPTED____FOSTER____
PERSON RESPONSIBLE FOR ACCOUNT____
ADDRESS______________________________________CITY________________POSTAL CODE__________
DO YOU HAVE AN INSURANCE PLAN WHICH COVERS ORTHODONTIC TREATMENT? YES☐ NO☐
FATHER'S NAME____BUS PHONE_______________
EMPLOYED BY____OCCUPATION______________________
MOTHER'S NAME____BUS PHONE_______________
EMPLOYED BY____OCCUPATION______________________

HOW WERE YOU REFERRED TO THIS OFFICE? (Dentist, family, friend, Yellow Pages, other)
____

MEDICAL HISTORY

Diabetes	☐	**Arthritis**	☐	**Gland Problems**	☐
Pneumonia	☐	**Anemia**	☐	**Prolonged Bleeding**	☐
Heart Trouble	☐	**Epilepsy**	☐	**Liver Involvement**	☐
Rheumatic Fever	☐	**Asthma**	☐	**Fainting and Dizziness**	☐
Bone Disorders	☐	**Kidney Involvement**	☐	**Nervous Disorder**	☐
AIDS/HIV	☐	**Hepatitis**	☐	**Sexually Transmitted Disease**	☐

	Yes	**No**
IS YOUR CHILD IN GOOD HEALTH?	☐	☐
IS YOUR CHILD UNDER A PHYSICIAN'S CARE NOW?	☐	☐
DOES YOUR CHILD HAVE ANY HISTORY OF MAJOR ILLNESS OR OPERATIONS?	☐	☐

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN, GIVE REASONS: _____________________

LIST ANY ALLERGIES OR DRUG SENSITIVITY: ____
DOES YOUR CHILD HAVE ANY TENDENCY TO COLDS___ SORE THROATS______
EAR INFECTIONS___
HAVE TONSILS AND ADENOIDS BEEN REMOVED? ______ WHAT AGE? ________________________
HAS CHILD REACH PUBERTY? _______ GIRLS - HAS SHE STARTED MENSTRUATION? ________
BOYS - HAS VOICE CHANGED? ________
IS THERE ANY HISTORY OF BIRTH DEVELOPMENTAL DEFECTS? ☐ ☐

IN THE LAST 24 HOURS HAS YOUR CHILD DEVELOPED A COUGH, SHORTNESS OF BREATH, FEVER OR CHILLS OR ONSET OF DIARRHEA? ____________________________________ ☐ ☐
DOES YOUR CHILD HAVE A NEW UNDIAGNOSED RASH, LESION, OR BREAK IN SKIN? ☐ ☐
HAS YOUR CHILD BEEN RECENTLY EXPOSED TO INFECTIOUS DISEASES? (eg. measles, chicken pox, tuberculosis) ☐ ☐

DOES YOUR CHILD HAVE A HISTORY OF JOINT PROSTHESES PROCEDURES IN THE PAST TWO YEARS? ☐ ☐

DOES YOUR CHILD HAVE A HISTORY OF ANTIMICROBIAL THERAPY? ☐ ☐

IS THERE FAMILY HISTORY OF PRIOR DISEASE, OR SYMPTOMS THAT MAY BE INDICATIVE OF CJD, SUCH AS SUDDEN ONSET DIMENTIA? ☐ ☐

HAS YOUR CHILD RECENTLY TRAVELED TO AREAS WHERE ENDEMIC DISEASES ARE PRESENT?
____ ☐ ☐

CHILD'S HEIGHT________ PARENT'S HEIGHT – MOTHER_________ FATHER________

DENTAL HISTORY

WHAT IS YOUR MAIN ORTHODONTIC CONCERN? ____
____

	Yes	No
HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH?	☐	☐
DOES YOUR CHILD HAVE ANY SPEECH PROBLEMS? ________________________	☐	☐
IS YOUR CHILD A MOUTH BREATHER WHILE AWAKE? YES__ NO__ WHILE SLEEPING? ________		
HAS YOUR CHILD SUCKED A THUMB OR FINGER? UNTIL WHAT AGE? _______________	☐	☐
HAS YOUR CHILD HAD ANY PREVIOUS ORTHODONTIC EXAMINATIONS? _____________	☐	☐
HAVE YOU BEEN INFORMED THAT YOUR CHILD IS MISSING OR HAS ANY EXTRA PERMANENT TEETH? ____	☐	☐
HAS EITHER PARENT HAD ORTHODONTIC TREATMENT? __________________________	☐	☐
HAS YOUR CHILD HAD ANY CLICKING OR DISCOMFORT IN JAW JOINT NEAR EARS?	☐	☐
DOES YOUR CHILD WANT ORTHODONTIC TREATMENT? __________________________	☐	☐
IS THERE ANOTHER FAMILY MEMBER WITH SIMILAR ORTHODONTIC PROBLEMS? ____	☐	☐
IS YOUR CHILD APPREHENSIVE ABOUT ORTHODONTIC TREATMENT? _______________	☐	☐
WHEN DID YOUR CHILD LAST VISIT YOUR DENTIST? ________________________________		
IS THERE ANY DENTAL TREATMENT STILL TO BE DONE? ___________________	☐	☐
DOES YOUR CHILD CLENCH OR GRIND HIS/HER TEETH? ______________________	☐	☐

HAVE YOUR CHILD'S TEETH ERUPTED EARLY? _____ AVERAGE____ LATE____

IS THERE ANYTHING WE SHOULD BE AWARE OF TO PROVIDE OPTIMUM CARE FOR YOUR CHILD?
____

LIST ANY MUSICAL INSTRUMENTS PLAYED____

LIST SPORTS, HOBBIES AND INTERESTS____

PARENT'S SIGNATURE______________________________