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ORTHODONTICS
specialist in orthodontics and dentofacial orthopedics for children and adults

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CHILD DENTAL AND MEDICAL HISTORY

Date _____

Name _____ Nickname _____
(first) (middle) (last)

Date of Birth _____ Age _____ Sex: M _____ F _____

Address _____ City _____ Zip _____

Phone (Home/Cell) _____ Email: _____

Work Phone - Mom _____ Work Phone - Dad _____

Family dentist _____ City _____ Phone _____

Family physician _____ CIty _____ Phone _____

School _____ CIty _____ Grade _____

Sports/Hobbies etc. _____

FAMILY HISTORY

Parents: Married_____ Separated _____ Divorced_____ Child Lives with _____

Father's Name _____ Social Security #_____ Birthdate_____

Address (if different from above) _____ Telephone_____

Employer Name and Address _____

Stepfather (if applicable) _____ Social Security #_____ Birthdate_____

Mother's Name _____ Social Security #_____ Birthdate_____

Address (if different from above)_____ Telephone_____

Employer Name and Address _____

Stepmother (if applicable)_____ Social Security #_____ Birthdate_____

Names and ages of brothers and sisters _____

Other family members with similar dental conditions (names and ages) _____

_____

Other family members with orthodontic treatment (including parents)_____

Have you had any other experiences with or seen another orthodontist? No _____ Yes _____ Name _____

MEDICAL HISTORY

General Health: Good _____ Fair _____ Poor _____ Height: _____ Weight _____

Birth defects _____

Presently under medical care for _____

Drugs or medications being taken now, including acne medications (drug and dose)_____

Allergic to what medication _____

Is pre-medication needed before dental appointments? ☐ Yes ☐ No

Please check yes or no to the following and date:

	Yes	No	Year
Adopted Child	☐	☐	_____
Adenoids (removed)	☐	☐	_____
Allergies	☐	☐	_____
Blood/Bleeding Problems	☐	☐	_____
Bone disorder	☐	☐	_____
Diabetes	☐	☐	_____
Ear/nose infections	☐	☐	_____
Emotional	☐	☐	_____
Endocrine disorder	☐	☐	_____
Epilepsy	☐	☐	_____
Fainting Spells	☐	☐	_____
Glaucoma	☐	☐	_____
Heart disorder murmur	☐	☐	_____
Hepatitis	☐	☐	_____
Hospitalized	☐	☐	_____
Hyperactivity	☐	☐	_____
Learning Disability	☐	☐	_____
Liver disorder	☐	☐	_____
Lung disorder	☐	☐	_____
Rheumatic fever Scoliosis	☐	☐	_____
Speech difficulty	☐	☐	_____
Tonsils (removed)	☐	☐	_____
Turners Syndrome	☐	☐	_____
Venereal disease	☐	☐	_____
Other_____			

Please give any additional information or details where necessary_____

PLEASE COMPLETE REVERSE SIDE

MATURATION

Have you grown very much in the past year? Yes _____ No _____ How many inches? _____

Female patients: Monthly Periods? Yes _____ No _____ started at age _____

Male Patients: Voice change? Yes _____ No _____ Facial Hair? Yes _____ No _____

Other indications of pubertal development _____

DENTAL HISTORY

Date of last dental check-up _____

Injury or trauma to the face or teeth _____

Brushing teeth: Several times per day_____ once a day _____ rarely_____

Does the patient play a musical instrument? _____

Thumb sucking _____ discontinued at the age of_____

Other habits: lip biting, nail biting specify_____

Jaw point (TMJ problems) noise _____ pain_____ earaches/ringing _____soreness & stiffness _____

Speech: difficulty in pronunciation Yes _____ No _____ Speech lessons Yes _____ No _____

PATIENT TREATMENT ATTITUDE

Major reason for seeking treatment_____

How did you become aware of the orthodontic problem? _____

Questionnaire completed by _____ relation to patient _____

LIFESAVING QUESTIONS

Does your child snore?	____ Yes	____ No
Does your child wake up tired and unrefreshed?	____ Yes	____ No
Is your child a restless sleeper?	____ Yes	____ No
Is your child often tired and cranky?	____ Yes	____ No
Does your child have large tonsils?	____ Yes	____ No
Does your child have a retrusive lower jaw (no chin)?	____ Yes	____ No
Does your child have constricted dental arches (crowded teeth)?	____ Yes	____ No
Does your child have dark circles under eyes (tired eyes)?	____ Yes	____ No
Does your child wet the bed?	____ Yes	____ No
Does your child have frequent bad dreams?	____ Yes	____ No
Does your child grind their teeth at night?	____ Yes	____ No

HOW DID YOU HEAR ABOUT US?

Referring new patients to our office is the highest compliment we can receive. Please take a moment to let us know all the ways you heard about our office. Put a check next to each source that applies, then circle the main reason you selected our office. Thank you!

____ Dentist
____ Family Member/Sibling
____ Friends/Co-workers
____ Building Sign
____ Advertisement
____ Internet
____ College Scholarships
____ Direct Mail
____ Office / School Tours
____ One of Dr. Hinesly's Employees
____ Other _____