PHOENIX ORTHODONTICS

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Child Medical History

Today's Date _____ ☐Male ☐Female
Child's Name _____
Last First MI
ss # _____ Nickname _____
Birthdate _____ Age _____
School _____ Grade _____
Hobbies/Sports _____
Child's Home # _____
Child's Home Address _____
_____
City State Zip

Who is accompanying your child today?
Name _____ Relation _____
Parent's marital status _____
Do you have legal custody of this child? ☐ Yes ☐No
How did you hear about us? _____
Other family members seen by us: _____
_____

General Dentist _____
Date of last check-up/cleaning: _____

☐Mother ☐ Step Mother ☐Guardian
Name _____ Birthdate _____
Work # _____ Home # _____
Employer _____
Email _____
How long at current job? _____ Title _____
SS # _____
Do you have dental insurance with orthodontic coverage?_

☐Father ☐ Step Father ☐Guardian
Name _____ Birthdate _____
Work # _____ Home # _____
Employer _____
Email _____
How long at current job? _____ Title _____
SS # _____
Do you have dental insurance with orthodontic coverage?_

Who will be responsible for making appointments?
_____
Who will be responsible for the account?
_____

What are your 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 or chin? ☐Yes ☐No
Has your child been informed of any missing or extra permanent teeth? ☐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
Floss his/her teeth daily? ☐Yes ☐No
Has puberty begun? ☐Yes ☐No
Has menstruation begun? (Girls) ☐Yes ☐No

Child's physician _____
Phone # _____ Date of last visit _____
Is your child currently under the care of a physician? _____
Please describe your child's current physical health:
☐Good ☐ Fair ☐ Poor
Please list all drugs your child is currently taking: _____
_____
Please list all drugs/things that your child is allergic to:
_____

Has your child ever had any of these medical problems?

Y N Abnormal Bleeding	Y N Hearing Impairment
Y N Allergies to any Drugs	Y N Heart Murmur
Y N Allergic to Latex/Metals	Y N Hemophilia
Y N Allergic to Plastic	Y N Hepatitis
Y N Asthma	Y N HIV+/AIDS
Y N Cancer	Y N Hospitalization
Y N Congenital Heart Defects	Y N Kidney/Liver Problems
Y N Convulsions/Epilepsy	Y N Operations
Y N Diabetes	Y N Rheumatic Fever
Y N Handicaps/Disabilities	Y N Tuberculosis (TB)

Please list any medical problems that your child has had:
_____
_____

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

Y N Clenching/Grinding	Y N Lip Sucking/Biting
Y N Nail Biting	Y N Tongue Thrust
Y N Mouth Breathing	Y N Thumb/Finger Sucking
Y N Soda Pop Drinker	

I understand that this information is correct and will be held in confidence and it is my responsibility to inform this office of any changes in medical status.

I authorize the dental staff to perform the necessary dental services my child may need, including diagnostic records (radiographs, impressions, photographs).

_____
Signature of parent or guardian Date

_____
Reviewed Date