



Child Information Form (Under 18 years)

Patient's Last name _____
Nickname or preferred name _____
Date of Birth (m/d/y) _____
Age _____ **Weight** _____ **Height** _____
E-mail (if available) _____
Patient's dentist _____
Who referred you to our office? _____
Person responsible for account _____

Patient's First name _____
Patient's Address _____
Sex: Male Female
School and Grade _____
Patient's physician _____
Emergency Contact Name _____
Emergency Contact Number _____

Mother

Name
Address
City
Postal code
Home phone
Work phone
Email

Father

Name
Address
City
Postal code
Home phone
Work phone
Email

Work

Occupation
Employer
Number of Years Employed
Insurance Co.
Group number
Certificate/ID

Work

Occupation
Employer
Number of Years Employed
Insurance Co.
Group number
Certificate/ID

Sibling Information

Number of brothers and their ages _____ sisters and their ages _____
 Does any one else have a similar condition? _____
 Have they been examined or treated for an orthodontic problem? _____

Medical and Dental Information

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Under the care of a physician within the last 5 years? Why? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. History of any serious illnesses? Please explain? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Currently taking any medications (vitamins, medicines or drugs)?
If yes, which ones? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have a history of, or have you ever been treated for (Please circle all answers which apply): | | |
| Cancer Rheumatic fever Blood pressure Thyroid disorders Anemia A.I.D.S. | | |
| Asthma Stomach disorders Heart trouble Eye trouble Epilepsy Other S.T.D.s | | |
| Sinusitis Liver disease Joint problems Kidney disease Hay fever Prosthetic Joints | | |
| Diabetes Blood disorders Tuberculosis Gall bladder Hepatitis | | |
| 5. Please list any allergies _____ | | |
| 6. Have you had any adverse effects from any anesthetic, antibiotic or other medical drugs?
If yes, which ones? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have shortness of breath or difficulty breathing through your nose or mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had any radiation or X-ray therapy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you get infections easily? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you have a heart murmur or heart disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you get night sweats? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you get frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has your jaw ever locked closed or open? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you grind or clench your teeth at night? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever had a clicking or popping noise in your ear? Please specify: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you or have you had a history of thumb or finger sucking? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. History of accident or trauma to face/head/teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Date: _____ Parent/Guardian's signature: _____