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 or chin? ☐ Yes ☐ No

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Has your child been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Has your child 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

Child's Physician? _____ Phone #: _____ Date of Last Visit: _____

Is your child currently under the care of a physician? ☐ Yes ☐ No

Please describe your child's current physical health: ☐ Good ☐ Fair ☐ Poor

Please list all drugs that your child is currently taking: _____

Has your child taken or presently taking medications for ADD/ADHD? ☐ Yes ☐ No

Please list all drugs / things your child is allergic to: _____

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

Y	N	Abnormal Bleeding	Y	N	Asthma	Y	N	Hemophilia
Y	N	ADD/ADHD	Y	N	Cancer	Y	N	Hepatitis
Y	N	Allergies to any Drugs	Y	N	Congenital Heart Defect	Y	N	HIV+ / AIDS
Y	N	Allergic to Latex / Metals	Y	N	Convulsions / Epilepsy	Y	N	Kidney / Liver Problems
Y	N	Allergic to Plastics	Y	N	Diabetes	Y	N	Lupus
Y	N	Any Hospital Stays	Y	N	Handicaps / Disabilities	Y	N	Rheumatic / Scarlet Fever
Y	N	Any Operations	Y	N	Hearing Impairment	Y	N	Tuberculosis (TB)
Y	N	Artificial Bones / Joints / Valves	Y	N	Heart Murmur			

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

_____

Does your child require antibiotics before any dental care? ☐ Yes ☐ No

Has your child ever experienced any of the following ?

Y	N	Clenching / Grinding Teeth	Y	N	Nail Biting	Y	N	Thumb / Finger Sucking = ongoing
Y	N	Lip Sucking / Biting	Y	N	Nursing Bottle Habits			or Stopped at age? _____
Y	N	Mouth Breather	Y	N	Speech Problems	Y	N	Tongue Thrust

The Parent or Guardian who accompanies the child is responsible for payment.

Our Office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I understand that the information that I have given is correct to the best of my 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's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of parent or guardian _____ **Date** _____

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I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Initials: _____ **Date:** _____ **Doctor's Comments:** _____

_____