



ORTHODONTICS FOR ADULTS AND CHILDREN

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ORTHODONTIC LICENSE #5286

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CHILD REGISTRATION AND HEALTH HISTORY

Date _____

Child's Name		Nickname		Age	Birthdate
Residence Address		City		State	Zip
School	Address			Grade	
Father's Name			Mother's Name		
Father Employed by		How long	Home Phone	Bus. Phone	
Mother Employed by		How long	Home Phone	Bus. Phone	
Father's Social Security Number			Driver License No.		State
Mother's Social Security Number			Driver License No.		State
Father's Birthdate			Mother's Birthdate		
Whom may we thank you for referring you					
What is child's favorite:	sport	toy	hobby	person	fictional character

DENTAL HISTORY

Date of last visit to a dentist _____	Yes	No	Does your child brush teeth daily _____	Yes	No
Has child complained about dental problems _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you assist child with tooth brushing _____	<input type="checkbox"/>	<input type="checkbox"/>
_____			How often _____		
Any unhappy dental experiences _____	<input type="checkbox"/>	<input type="checkbox"/>	Is dental floss used _____	<input type="checkbox"/>	<input type="checkbox"/>
_____			How often _____		
Any injuries to mouth - teeth - head _____	<input type="checkbox"/>	<input type="checkbox"/>	Is fluoride taken in any form _____	<input type="checkbox"/>	<input type="checkbox"/>
_____			_____		
Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc. _____	<input type="checkbox"/>	<input type="checkbox"/>	Child's attitude to dentistry _____		
_____			_____		
Any unusual speech habits _____	<input type="checkbox"/>	<input type="checkbox"/>	_____		

Any lost teeth _____	<input type="checkbox"/>	<input type="checkbox"/>			

Have missing teeth been replaced _____	<input type="checkbox"/>	<input type="checkbox"/>			

Orthodontic appliances worn now or ever been _____	<input type="checkbox"/>	<input type="checkbox"/>			

Other side, please

HEALTH HISTORY

Child's physician _____ Address _____ Phone _____

Date of last physical examination _____ Results _____

Is child under care of physician now _____	Yes No <input type="checkbox"/> <input type="checkbox"/>	Does child have good physical coordination _____	Yes No <input type="checkbox"/> <input type="checkbox"/>
Is child receiving any medication or drugs _____	<input type="checkbox"/> <input type="checkbox"/>	Are there any emotional problems _____	<input type="checkbox"/> <input type="checkbox"/>
Is there any excessive bleeding when cut _____	<input type="checkbox"/> <input type="checkbox"/>		
Has child ever been hospitalized _____	<input type="checkbox"/> <input type="checkbox"/>		
Has child ever had surgery _____	<input type="checkbox"/> <input type="checkbox"/>		
Is there any allergy to penicillin or other drugs _____	<input type="checkbox"/> <input type="checkbox"/>		
Are there other allergies: food - pollen - animals - dust - other _____	<input type="checkbox"/> <input type="checkbox"/>		

Has child any history of or difficulty with any of the following:

- | | | | | |
|--------------------|-------------------|------------------|---------------------|----------------------|
| ___ Anemia | ___ Chronic Sinus | ___ Hearing | ___ Mastoid | ___ Thyroid |
| ___ Asthma | ___ Convulsions | ___ Heart | ___ Measles | ___ Tuberculosis |
| ___ Bladder | ___ Diabetes | ___ Kidney | ___ Mononucleosis | ___ Venereal Disease |
| ___ Cerebral Palsy | ___ Epilepsy | ___ Liver | ___ Mumps | ___ Other |
| ___ Chicken Pox | ___ Fainting | ___ Malignancies | ___ Rheumatic Fever | |

Summary: (for doctor's use)

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed.

My we request release of your child's medical records _____ Yes No

This information was discussed with and given by _____

Relationship to child _____