# CHILD HEALTH HISTORY AND CONSENT/PATIENT INFORMATION


***We would like to welcome you and your child to our office.*** Our goal is to make every child's visit fun and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

**ABOUT YOUR CHILD** ❑ Male ❑ Female Today's date _____

Name _____ Birthdate _____

Prefers to be called _____ School _____ Grade _____

Home phone _____ Mobile _____ Email _____

Home address _____ City _____ State _____ Zip _____

**WHO IS ACCOMPANYING YOUR CHILD TODAY?**

Name _____ Relation _____

Legal custody of the child? ❑ yes ❑ no Parent's marital status: ❑ Married ❑ Separated ❑ Divorced ❑ Single ❑ Widowed

Referred by? _____ Siblings/ages _____

General dentist _____ Date of last visit _____

**MOTHER'S INFORMATION** ❑ Stepmother ❑ Guardian

Name _____ Birthdate _____

I prefer to be called _____ SS# _____

Home phone _____ Work _____ Mobile _____

Mobile carrier (for text reminders) _____ Best way to reach you ❑ home ❑ cell ❑ email

Employer's name _____ How long there? _____ Title _____

**FATHER'S INFORMATION** ❑ Stepfather ❑ Guardian

Name _____ Birthdate _____

I prefer to be called _____ SS # _____

Home phone _____ Work _____ Mobile _____

Mobile carrier (for text reminders) _____ Best way to reach you ❑ Home ❑ Cell ❑ Email

Employer's name _____ How long there? _____ Title _____

**PERSON RESPONSIBLE FOR THE ACCOUNT** ❑ Father ❑ Mother ❑ Other _____

**PRIMARY INSURANCE** Orthodontic Coverage ❑ Yes ❑ No Dental Coverage ❑ Yes ❑ No

Insurance company name _____ Phone _____

Insurance company address _____ City _____ State _____ Zip _____

Group # _____ Id # _____

Policy holder's name _____ Relation _____ Birthdate _____

Policy holder's employer _____ Policy Holder's SS # _____

**YOUR CHILD'S HISTORY** **Current dental health is:** ❑ Good ❑ Fair ❑ Poor

**What are the main concerns that you would like Martin Orthodontics to address?** _____

_____

_____

**Has/Does your child:**

- ever been evaluated or received orthodontic treatment? ❑ Yes ❑ No
- ever had any injuries to the face, mouth, teeth or chin? ❑ Yes ❑ No
- had adenoids or tonsils removed? ❑ Yes ❑ No
- been informed of any missing or extra permanent teeth? ❑ Yes ❑ No
- **ever had pain/tenderness in their jaw joint (TMJ / TMD)?** ❑ Yes ❑ No
- brush their teeth daily? ❑ Yes ❑ No
- floss their teeth daily? ❑ Yes ❑No

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

Child's physician _____ Phone _____ Date of last visit _____

Has puberty begun? ❑ Yes ❑ No Has menstruation begun (girls)? ❑ Yes ❑ No

Has your child ever taken Phen-Fen? ❑ Yes ❑ No *(Also known as Redux or Pondimin)* If yes, when? _____

List any musical instruments played _____

**Current physical health is:** ❑ Good ❑ Fair ❑ Poor

please list any drugs your child is currently taking _____

_____

**Is your child allergic to any of the following?**

Aspirin ❑ Yes ❑ No Codeine ❑ Yes ❑ No Latex ❑ Yes ❑ No Metal/plastics ❑ Yes ❑ No Penicillin ❑ Yes ❑ No

Tetracycline ❑ Yes ❑ No Other ❑ Yes ❑ No _____

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

| | | | |
|---|---|---|---|
| Y N abnormal bleeding | Y N artificial bones/joints/valves | Y N handicaps/disabilities | Y N liver problems |
| Y N ADD/ADHD | Y N asthma | Y N hearing impairment | Y N lupus |
| Y N allergies to any drugs | Y N cancer | Y N heart murmur | Y N rheumatic/scarlet fever |
| Y N any hospital stays | Y N congenital heart defect | Y N hehemophilia | Y N sickle cell disease/traits |
| Y N any operations | Y N convulsions/epilepsy | Y N HIV+ / AIDS | Y N tuberculosis (TB) |
| | Y N diabetes | Y N kidney problems | |

Please discuss any medical problems that your child has had _____

_____

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

| | | |
|---|---|---|
| Y N clenching/grinding teeth | Y N nail biting | Y N thumb/finger sucking |
| Y N lip sucking/biting | Y N nursing bottle | Y N tongue thrust |
| Y N mouth breather | Y N speech problems | Y N was your child breast fed? |

## AUTHORIZATION

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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**Doctor's Comments:**

_____

_____

_____

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

Initials _____ Date _____