



**CHILD DENTAL AND MEDICAL HISTORY**

Date \_\_\_\_\_

Name \_\_\_\_\_ (first) \_\_\_\_\_ (middle) \_\_\_\_\_ (last) Nickname \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone (Home/Cell) \_\_\_\_\_ Email: \_\_\_\_\_

Work Phone - Mom \_\_\_\_\_ Work Phone - Dad \_\_\_\_\_

Family dentist \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_

Family physician \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_

School \_\_\_\_\_ City \_\_\_\_\_ Grade \_\_\_\_\_

Sports/Hobbies etc. \_\_\_\_\_

**FAMILY HISTORY**

Parents: Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Child Lives with \_\_\_\_\_

Father's Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_

Address (if different from above) \_\_\_\_\_ Telephone \_\_\_\_\_

Employer Name and Address \_\_\_\_\_

Stepfather (if applicable) \_\_\_\_\_ Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_

Mother's Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_

Address (if different from above) \_\_\_\_\_ Telephone \_\_\_\_\_

Employer Name and Address \_\_\_\_\_

Stepmother (if applicable) \_\_\_\_\_ Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_

Names and ages of brothers and sisters \_\_\_\_\_

Other family members with similar dental conditions (names and ages) \_\_\_\_\_

Other family members with orthodontic treatment (including parents) \_\_\_\_\_

Have you had any other experiences with or seen another orthodontist? No \_\_\_\_\_ Yes \_\_\_\_\_ Name \_\_\_\_\_

**MEDICAL HISTORY**

General Health: Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_ Height: \_\_\_\_\_ Weight \_\_\_\_\_

Birth defects \_\_\_\_\_

Presently under medical care for \_\_\_\_\_

Drugs or medications being taken now, including acne medications (drug and dose) \_\_\_\_\_

Allergic to what medication \_\_\_\_\_

Is pre-medication needed before dental appointments?  Yes  No

Please check yes or no to the following and date:

	Yes	No	Year		Yes	No	Year		Yes	No	Year		Yes	No	Year
Adopted Child	<input type="checkbox"/>	<input type="checkbox"/>	_____	Emotional	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Adenoids (removed)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Endocrine disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hospitalized	<input type="checkbox"/>	<input type="checkbox"/>	_____	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	_____	Speech difficulty	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood/Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	_____	Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tonsils (removed)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bone disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Liver disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Turners Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart disorder murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lung disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/nose infections	<input type="checkbox"/>	<input type="checkbox"/>	_____									Other	_____		

Please give any additional information or details where necessary \_\_\_\_\_

**PLEASE COMPLETE REVERSE SIDE**

## MATURATION

Have you grown very much in the past year? Yes \_\_\_\_\_ No \_\_\_\_\_ How many inches? \_\_\_\_\_  
Female patients: Monthly Periods? Yes \_\_\_\_\_ No \_\_\_\_\_ started at age \_\_\_\_\_  
Male Patients: Voice change? Yes \_\_\_\_\_ No \_\_\_\_\_ Facial Hair? Yes \_\_\_\_\_ No \_\_\_\_\_  
Other indications of pubertal development \_\_\_\_\_

## DENTAL HISTORY

Date of last dental check-up \_\_\_\_\_  
Injury or trauma to the face or teeth \_\_\_\_\_  
Brushing teeth: Several times per day \_\_\_\_\_ once a day \_\_\_\_\_ rarely \_\_\_\_\_  
Does the patient play a musical instrument? \_\_\_\_\_  
Thumb sucking \_\_\_\_\_ discontinued at the age of \_\_\_\_\_  
Other habits: lip biting, nail biting specify \_\_\_\_\_  
Jaw point (TMJ problems) noise \_\_\_\_\_ pain \_\_\_\_\_ earaches/ringing \_\_\_\_\_ soreness & stiffness \_\_\_\_\_  
Speech: difficulty in pronunciation Yes \_\_\_\_\_ No \_\_\_\_\_ Speech lessons Yes \_\_\_\_\_ No \_\_\_\_\_

## PATIENT TREATMENT ATTITUDE

Major reason for seeking treatment \_\_\_\_\_  
How did you become aware of the orthodontic problem? \_\_\_\_\_  
Questionnaire completed by \_\_\_\_\_ relation to patient \_\_\_\_\_

## LIFESAVING QUESTIONS

Does your child snore?	___ Yes	___ No
Does your child wake up tired and unrefreshed?	___ Yes	___ No
Is your child a restless sleeper?	___ Yes	___ No
Is your child often tired and cranky?	___ Yes	___ No
Does your child have large tonsils?	___ Yes	___ No
Does your child have a retrusive lower jaw (no chin)?	___ Yes	___ No
Does your child have constricted dental arches (crowded teeth)?	___ Yes	___ No
Does your child have dark circles under eyes (tired eyes)?	___ Yes	___ No
Does your child wet the bed?	___ Yes	___ No
Does your child have frequent bad dreams?	___ Yes	___ No
Does your child grind their teeth at night?	___ Yes	___ No

## HOW DID YOU HEAR ABOUT US?

Referring new patients to our office is the highest compliment we can receive. Please take a moment to let us know all the ways you heard about our office. Put a check next to each source that applies, then circle the main reason you selected our office. Thank you!

___ Dentist	___ Family Member/Sibling	___ Friends/Co-workers
___ Building Sign	___ Advertisement	___ Internet
___ College Scholarships	___ Direct Mail	___ Office / School Tours
___ One of Dr. Hinesly's Employees	___ Other _____	