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ORTHODONTICS
specialist in orthodontics and dentofacial orthopedics for children and adults

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CHILD DENTAL AND MEDICAL HISTORY

Date _____

Name _____ Nickname _____
(first) (middle) (last)

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) _____

Medication Allergies _____

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	☐	☐	_____	Emotional Issues	☐	☐	_____	Hepatitis	☐	☐	_____	Speech difficulty	☐	☐	_____
Adenoids (removed)	☐	☐	_____	Endocrine disorder	☐	☐	_____	Hospitalized	☐	☐	_____	Tonsils (removed)	☐	☐	_____
Allergies	☐	☐	_____	Epilepsy	☐	☐	_____	Learning Disability	☐	☐	_____	Turners Syndrome	☐	☐	_____
Blood/Bleeding Problems	☐	☐	_____	Fainting Spells	☐	☐	_____	Lung disorder	☐	☐	_____	Other _____			
Bone disorder	☐	☐	_____	Glaucoma	☐	☐	_____								
Diabetes	☐	☐	_____	Heart disorder murmur	☐	☐	_____								
Ear/nose infections	☐	☐	_____												

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 _____	