What are the main concerns that you would like orthodontics to accomplish?

___

___

Has the child ever been evaluated or had orthodontic treatment in the past?
☐ YES ☐ NO

Have there been any injuries to the mouth, teeth or chin?
☐ YES ☐ NO

List any musical instruments played

___

Have adenoids or tonsils been removed?
☐ YES ☐ NO

Has your child been informed of any missing teeth or extra permanent teeth?
☐ YES ☐ NO

Has the child ever had any pain/ tenderness in his/her jaw joint (TMJ/TMD)?
☐ YES ☐ NO

Does the child brush his/her teeth daily?
☐ YES ☐ NO

Floss his/her 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

Please describe the child's current physical health:
☐GOOD ☐FAIR ☐POOR

Please list all drugs that the child is currently taking:

___

___

Please list all drugs/things that the child is allergic to:

___

___

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

Y N Abnormal Bleeding	Y N Handicaps/Disabilities
Y N Allergies to any drugs	Y N Hearing Impairment
Y N Allergic to Latex/Medals	Y N Heart Murmur
Y N Allergic to plastics	Y N Hemophilia
Y N Any Hospital Stays	Y N Hepatitis
Y N Asthma	Y N HIV+/AIDS
Y N Cancer	Y N Kidney/Liver Problems
Y N Congenital Heart Defect	Y N Rheumatic/Scarlet Fever
Y N Convulsions/Epilepsy	Y N Tuberculosis (TB)
Y N Diabetes	

Please discuss any serious medical problems that the child has had:

___

___

___

Does/did the child have any of the following:

Y N Clenching/Grinding teeth	Y N Nursing Bottle Habits
Y N Lip Sucking/Biting	Y N Speech Problems
Y N Mouth Breather	Y N Thumb/Finger Sucking
Y N Nail Biting	Y N Tongue Thrust

Who does your child see for dental treatments:

☐ Casa Smiles ☐ Other ___

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.

___ ___

Patients Name Signature of Parent or Guardian Date

The parent or guardian who accompanies the child is responsible for payment at times of service unless prior arrangements have been made. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDA and the ADA