

pediatric dental center

Child Orthodontic Examination Form

Child's Full Name _____ Nickname _____

Birthdate _____ Age _____ Sex _____ School _____ Grade _____

Address _____ City _____ State _____ Zip _____

Home Number _____ Email _____

Who is the legal Guardian? _____

Father's Name _____ Birthdate _____

Father's Address _____

Father's Employer _____ Work Phone # _____

Father's Dental Insurance _____ Father's Contract #/SSN _____

Mother's Name _____ Birthdate _____

Mother's Address _____

Mother's Employer _____ Work Phone # _____

Mother's Dental Insurance _____ Mother's Contract #/SSN _____

Does your child play a musical instrument? _____ What instrument? _____

Does your child play sports? _____ Please list _____

Does your child have any hobbies? _____ Please list _____

HEALTH HISTORY

Dentist _____ Dentist's Phone _____

Dentist's Address _____

Physician _____ Physician's Phone _____

Physician's Address _____

Does your child have physical, emotional or mental impairment? _____

If yes, explain _____

Has your child had a history of any of the following disorders? If yes, please check:

- | | | | | |
|---------------------------------------------|----------------------------------------|--------------------------------------------|-----------------------------------------|---------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Drug Allergy | <input type="checkbox"/> HIV Positive/AIDS | <input type="checkbox"/> Nickel Allergy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Sickle Cell | |

Comments/Other _____

Is your child being seen by a physician at this time? _____ If yes, why _____

Is your child on medication? _____ If yes, please list _____

Has there ever been an injury to the mouth, jaw or teeth? _____

Who referred you? _____

Alternate Emergency Number

Name _____ Relationship _____ Phone # _____

I hereby authorize an orthodontic dental examination as deemed necessary.

Signature of Parent or Guardian: _____ Date _____

Relationship to Patient: _____