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:

- ❒ Asthma
- ❒ Bleeding
- ❒ Blood Transfusions
- ❒ Convulsions
- ❒ Diabetes
- ❒ Drug Allergy
- ❒ Heart Disease
- ❒ Heart Murmur
- ❒ Hepatitis
- ❒ HIV Positive/AIDS
- ❒ Kidney Disease
- ❒ Latex Allergy
- ❒ Liver Disease
- ❒ Nickel Allergy
- ❒ Seizures
- ❒ Sickle Cell
- ❒ Surgery
- ❒ Tuberculosis

Comments/Other ____

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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: ____