C H I L D P A T I E N T A C Q U A I N T A N C E F O R M

Today's Date: _____/_____/_____

Patient's Name: _____ Sex: M F Birth Date _____/ _____/ _____
D M Y

Address: _____ Age: _____Years _____Months
Street Apt #

_____ Home Phone: _____
City/Town Postal Code

Name of School: _____ Grade: _____

Parent/Guardian's Name _____ Daytime No.:_____

EmailAddress:_____

Parent/Guardian's Name _____ Daytime No.:_____

Email Address:_____

Person Responsible for the Account:

Name: _____ Relationship to Patient _____
Address: _____ Phone# Home: _____ Business:_____
Street City/Town

Who may we thank for referring you to our office? _____

Family Dentist: _____ Date of last dental visit: _____
Frequency of dental check-ups and cleanings: _____ Date of most recent x-rays: _____
Please list specific dental concerns: _____
_____

Please circle the appropriate response:

Are any of your teeth becoming loose?	Yes	No	Do your gums bleed when brushing or flossing?	Yes	No
Have any of your teeth shifted?	Yes	No	Have you had problems with tonsils or adenoids?	Yes	No
Does food get caught between your teeth?	Yes	No	Have any of your relatives had orthodontic treatment?	Yes	No Not Sure
Is there a history of gum disease in your family?	Yes	No			

Are any of your teeth sensitive to: □cold □hot □biting □pressure □sweet

Have you had previous orthodontic treatment: Yes No If yes, please explain: _____
_____
_____

What I like the most about my smile is: _____
_____

What I would like to change about my smile is: _____
_____

Do you have any concerns regarding your appearance (profile, symmetry, etc) that you would like changed? □Yes □No
Please Specify:_____
_____

Family Physician: _____
Name and Address

M E D I C A L H I S T O R Y

Date:_____/_____/_____

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present time or within the past year? ☐ Yes ☐ No ☐ Not sure/Maybe
   If yes, please specify: _____
2. When was your last medical checkup? _____
3. Has there been any change in your general health in the past year? ☐ Yes ☐ No ☐ Not sure/Maybe
   If yes, please explain: _____
4. Are you presently taking any medications, non-prescription drugs or herbal supplements of any kind? ☐ Yes ☐ No ☐ Not sure/Maybe
   If yes, please list: _____
5. Do you have any allergies? ☐ Yes ☐ No ☐ Not sure/Maybe
   If yes, please list using the categories below:
   A: Medications/Drugs
   B: Latex/rubber products
   C: Other eg. Hayfever, foods _____
6. Have you ever had a peculiar or adverse reaction to any medicines or injections? ☐ Yes ☐ No ☐ Not sure/Maybe
   If yes, please specify: _____
7. Do you have any prosthetic or artificial joints or implants (e.g. Hip, TMJ) ☐ Yes ☐ No ☐ Not sure/Maybe
   If yes, please specify: _____
8. Have you ever been advised by your doctor to take antibiotics before dental treatment? ☐ Yes ☐ No ☐ Not sure/Maybe
9. Do you have any conditions or therapies that could affect your immune system e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? ☐ Yes ☐ No ☐ Not sure/Maybe
10. Have you ever been hospitalized for any illnesses or operations? ☐ Yes ☐ No ☐ Not sure/Maybe
    If yes, please specify: _____

11. Do you have or have you ever had any of the following? Please check.

☐ Anemia	☐ Chicken pox	☐ Mitral valve prolapse
☐ Arthritis	☐ Diabetes	☐ Mumps
☐ Artificial heart valves	☐ Epilepsy	☐ Pacemaker
☐ Artificial joints	☐ Heart problems	☐ Rheumatic fever
☐ Asthma	☐ Heart murmur	☐ Scarlet fever
☐ Bleeding disorders	☐ Hepatitis	☐ Tuberculosis or TB
☐ Bleeding problems	☐ Jaundice	☐ Ulcer
☐ Blood pressure problems	☐ Liver disease	
	☐ Measles	

12. Are there any conditions or diseases not listed above that you have or have had? ☐ Yes ☐ No ☐ Not sure/Maybe, If so, what?
    _____
13. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) ☐ Yes ☐ No ☐ Not sure/Maybe
    _____
14. Do you smoke or chew tobacco products? ☐ Yes ☐ No
15. Are you nervous during dental treatment? ☐ Yes ☐ No
16. For women only: Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date? ☐ Yes ☐ No ☐ Not sure/Maybe
17. For children only: Girls: Has menstruation started? ☐Yes ☐ No Boys: Has voice changed yet? ☐ Yes ☐ No

_____

General Release of Information

I certify that I have read, understood and accurately completed the personal medical and dental histories of the patient to the best of my knowledge and have not knowingly omitted any information. As may be required, I consent to my physician being contacted regarding any specific medical questions. I also consent to my general dentist or any other dental specialist being notified regarding the orthodontic examination and treatment progress as is deemed necessary from time to time.

Patient ☐ Parent ☐ Guardian ☐ Date:_____Signature _____