



**Child History Form**

Patient's Full Name: \_\_\_\_\_ Likes to be called: \_\_\_\_\_ Sex: M F Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ School: \_\_\_\_\_ Child lives with: Mom Dad Both Other: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Email: \_\_\_\_\_

Address of responsible party: \_\_\_\_\_ Phone number of responsible party: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_ Family we have seen: \_\_\_\_\_

- Yes No Is the patient in good health? \_\_\_\_\_
- Yes No Does the patient have any medical condition?  
If yes, what? \_\_\_\_\_
- Yes No Does the patient take any medicine? What? \_\_\_\_\_
- Yes No Does the patient have any allergies to medicines, latex, or nickel? What? \_\_\_\_\_
- Yes No Has the patient ever had any surgery or hospitalizations? For what? \_\_\_\_\_

Patient's Physician's Name: \_\_\_\_\_

Does the patient have, or has the patient ever had any of the following:

- |     |    |                                    |     |    |                       |     |    |                     |
|-----|----|------------------------------------|-----|----|-----------------------|-----|----|---------------------|
| Yes | No | Artificial Heart Valve             | Yes | No | Heart Disease         | Yes | No | Hepatitis           |
| Yes | No | Infective Endocarditis             | Yes | No | Rheumatic fever       | Yes | No | HIV/AIDS            |
| Yes | No | Heart Condition present from birth | Yes | No | Heart Murmur          | Yes | No | Allergy to Latex    |
|     |    |                                    | Yes | No | Mitral Valve Prolapse | Yes | No | Allergies/ Hayfever |

Dentist: \_\_\_\_\_ Last dental visit: \_\_\_\_\_

- Yes No Have there been any injuries to the face, mouth, or teeth? \_\_\_\_\_
- Yes No Has the patient ever sucked a thumb or finger? Until what age? \_\_\_\_\_
- Yes No Any missing or extra permanent teeth? \_\_\_\_\_
- Yes No Has an orthodontist been consulted previously? Who? \_\_\_\_\_
- Yes No Does the patient clench or grind the teeth at night? \_\_\_\_\_
- Yes No Does the patient have a click or pop of the jaw joint? \_\_\_\_\_
- Yes No Does the patient have or has had any jaw pain? \_\_\_\_\_
- Yes No Does the patient have gum disease or any previous gum treatment? \_\_\_\_\_

What are your primary concerns? \_\_\_\_\_

I, the undersigned, have given the information, have reviewed it, and find it accurate and complete. I consent to the use of photographs for educational / marketing purposes.

Signature (Parent's signature if minor): \_\_\_\_\_ Date: \_\_\_\_\_