

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your child's dental care. All information will be kept completely confidential.

### MEDICAL HISTORY - CHILD

Physician's Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Is your child currently taking any medications? No\_\_ Yes\_\_ List \_\_\_\_\_

Does your child have any allergies? No\_\_ Yes\_\_ List \_\_\_\_\_

Have your child's tonsils or adenoids been removed? No\_\_ Yes\_\_ When \_\_\_\_\_

Has your child been treated for sleep apnea? No\_\_ Yes\_\_ When? \_\_\_\_\_

Does your child have any allergic reaction to latex or metal? \_\_\_\_\_ If yes, please list \_\_\_\_\_

Do you have any health concerns regarding orthodontic treatment? \_\_\_\_\_

Comments \_\_\_\_\_

Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are needed to aid in our selection of treatment alternatives.

Has your son or daughter reached puberty?..... No\_\_ Yes\_\_

Girls - Has she started menstruation?..... No\_\_ Yes\_\_ When? \_\_\_\_\_

Boys - Has his voice changed?..... No\_\_ Yes\_\_ When? \_\_\_\_\_

Height \_\_\_\_\_ Do you feel growth is completed? No\_\_ Yes\_\_

Father's Height \_\_\_\_\_ Mother's Height \_\_\_\_\_ Adopted? No\_\_ Yes\_\_

Have either siblings or parents had orthodontic treatment? No\_\_ Yes\_\_ With whom? \_\_\_\_\_

### DENTAL HISTORY

Dentist's Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Frequency of dental checks:

Twice a year\_\_ Once a year\_\_ Only if a problem exists\_\_ Never\_\_ Date of last visit \_\_\_\_\_

Is there any unfinished care to be completed with your child's dentist? No\_\_ Yes\_\_ Explain \_\_\_\_\_

Has your child had any face or dental injuries? No\_\_ Yes\_\_ Explain \_\_\_\_\_

Is there any history of thumb or finger sucking? No\_\_ Yes\_\_ Stopped? \_\_\_\_\_

Does your child play a musical instrument? No\_\_ Yes\_\_ Which? \_\_\_\_\_

Have teeth (either primary or permanent) been removed? No\_\_ Yes\_\_

Has your child had any previous orthodontic treatment? No\_\_ Yes\_\_ With whom? \_\_\_\_\_

Please check if there is a history of:

Clenching teeth\_\_ Muscular soreness around head and neck\_\_ Jaw joint soreness\_\_ Grinding teeth\_\_

Is there any other information that may be helpful? \_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_ Reviewed by \_\_\_\_\_