Child Orthodontic Medical History

PATIENT'S NAME:

BIRTH DATE: AGE:

SCHOOL:

RESPONSIBLE PARTY Dr. ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. ❑

NAME:

ADDRESS:

(STREET)

(CITY) (POSTAL CODE)

RESIDENCE TEL:

BUSINESS TEL (MOTHER):

BUSINESS TEL (FATHER):

PATIENT'S CELL: EMAIL:

REFFERRED BY:

DENTIST'S NAME:

DENTAL INSURANCE: Yes ❑ No ❑

1. WHAT ORTHODONTIC CONCERNS DO YOU HAVE ABOUT YOUR CHILD'S TEETH OR MOUTH?
   (Please specify.)
2. HAS YOUR CHILD OR ANY OTHER MEMBER OF YOUR FAMILY EXPERIENCED ORTHODONTIC TREATMENT? Yes ❑ No ❑
   (If yes, who?)
3. HAS YOUR CHILD SUFFERED ANY SEVERE ACCIDENTS INVOLVING: Face ❑ Teeth ❑ Jaws ❑ None ❑
4. DOES YOUR CHILD HAVE ALLERGIES RELATED TO: Asthma ❑ Hayfever ❑ Drugs ❑ Latex ❑ None ❑
5. DOES YOUR CHILD HAVE DIFFICULTY BREATHING THROUGH HIS/HER NOSE? Yes ❑ No ❑
6. DOES YOUR CHILD HAVE ANY ORAL HABITS SUCH AS: Thumb-sucking ❑ Finger-sucking ❑ Tongue-thrusting ❑ None ❑
   Other ❑ (please list.)
7. HAVE YOUR CHILD'S TONSILS AND/OR ADENOIDS BEEN REMOVED? Yes ❑ No ❑ (If so, when?) ______________________________
8. HAS YOUR CHILD EXPERIENCED ANY COMPLEX OR UNUSUAL DENTAL TREATMENT? Yes ❑ No ❑
   (If so, please explain.)
9. IS YOUR CHILD PRESENTLY IN GOOD GENERAL HEALTH? Yes ❑ No ❑ PHYSICIAN'S NAME: ______________________________
10. IS YOUR CHILD PRESENTLY UNDER A PHYSICIAN'S CARE FOR ANYTHING THAT IS OTHER THAN ROUTINE? Yes ❑ No ❑
    (If so, for what reason?)
11. IS YOUR CHILD CURRENTLY TAKING ANY MEDICATION? Yes ❑ No ❑
    (If so, please list.)
12. HAS YOUR CHILD EVER BEEN ADMITTED TO A HOSPITAL? Yes ❑ No ❑
    (If so, for what reason?)
13. HAS YOUR CHILD EVER EXPERIENCED ANY SERIOUS ILLNESSES SUCH AS: Rheumatic Fever ❑ Auto Immune Disease ❑ Hepatitis ❑
    Vascular Disorders ❑ Artificial Joints, Heart Valves, etc. ❑ Heart Disease ❑ None ❑
    Other ❑ (please list.)
14. HAVE YOU EXPERIENCED, CLICKING OF THE JAW, PAIN OR DIFFICULT CHEWING? Yes ❑ No ❑ (If so, when?) ______________________

Our office complies with privacy legislation, the regulations of the Royal College of Dental Surgeons of Ontario and the law . Please be assured that every team member in our office is committed to protecting your personal health information.

The above medical history is correct to the best of my knowledge. I authorize my Doctor to consult with and/or send reports to medical and/or dental practitioners as it relates to orthodontic treatment.

Signature parent or guardian *Date*