# Child Information Form (Under 18 years)

**Patient's Last name** _____ **Patient's First name**_____
**Nickname** or preferred name _____ **Patient's Address** _____
**Date of Birth** (m/d/y) _____ **Sex:** Male ☐ Female ☐
**Age** _____ **Weight** _____ **Height** _____ **School and Grade** _____
**E-mail** (if available) _____
**Patient's dentist** _____ **Patient's physician** _____
**Who referred you to our office?** _____ **Emergency Contact Name**_____
**Person responsible for account** _____ **Emergency Contact Number**_____

| **Mother** | |
|---|---|
| | Name |
| | Address |
| | City |
| | Postal code |
| | Home phone |
| | Work phone |
| | Email |

| **Father** | |
|---|---|
| | Name |
| | Address |
| | City |
| | Postal code |
| | Home phone |
| | Work phone |
| | Email |

Work

| | |
|---|---|
| | Occupation |
| | Employer |
| | Number of Years Employed |
| | Insurance Co. |
| | Group number |
| | Certificate/ID |

Work

| | |
|---|---|
| | Occupation |
| | Employer |
| | Number of Years Employed |
| | Insurance Co. |
| | Group number |
| | Certificate/ID |

**Sibling Information**

Number of brothers and their ages_____sisters and their ages _____
Does any one else have a similar condition? _____
Have they been examined or treated for an orthodontic problem? _____

**Medical and Dental Information**

| | Yes | No |
|---|---|---|
| 1. Under the care of a physician within the last 5 years? Why? _____ | ☐ | ☐ |
| 2. History of any serious illnesses? Please explain? _____ | ☐ | ☐ |
| 3. Currently taking any medications (vitamins, medicines or drugs)? | ☐ | ☐ |
| If yes, which ones?_____ | | |

4. Do you have a history of, or have you ever been treated for (Please circle all answers which apply):

| | | | | | |
|---|---|---|---|---|---|
| Cancer | Rheumatic fever | Blood pressure | Thyroid disorders | Anemia | A.I.D.S. |
| Asthma | Stomach disorders | Heart trouble | Eye trouble | Epilepsy | Other S.T.D.s |
| Sinusitis | Liver disease | Joint problems | Kidney disease | Hay fever | Prosthetic Joints |
| Diabetes | Blood disorders | Tuberculosis | Gall bladder | Hepatitis | |

| | | |
|---|---|---|
| 5. Please list any allergies _____ | | |
| 6. Have you had any adverse effects from any anesthetic, antibiotic or other medical drugs? | ☐ | ☐ |
| If yes, which ones?_____ | | |
| 7. Do you have shortness of breath or difficulty breathing through your nose or mouth? | ☐ | ☐ |
| 8. Have you ever had any radiation or X-ray therapy? | ☐ | ☐ |
| 9. Do you get infections easily? | ☐ | ☐ |
| 10. Do you have a heart murmur or heart disease? | ☐ | ☐ |
| 11. Do you get night sweats? | ☐ | ☐ |
| 12. Do you get frequent headaches? | ☐ | ☐ |
| 13. Has your jaw ever locked closed or open? | ☐ | ☐ |
| 14. Do you grind or clench your teeth at night? | ☐ | ☐ |
| 15. Have you ever had a clicking or popping noise in your ear? Please specify: _____ | ☐ | ☐ |
| 16. Do you or have you had a history of thumb or finger sucking? | ☐ | ☐ |
| 17. History of accident or trauma to face/head/teeth? _____ | ☐ | ☐ |

Date:_____ Parent/Guardian's signature:_____