



Child Health History Form

Date _____

Child's name _____ Date of birth _____ Male Female
LAST FIRST MI
 Address _____ Phone _____
STREET CITY STATE ZIP
 School _____ Grade _____ Referred by _____
 Child's dentist _____ Child's physician _____

Parent's Information

Father _____ Occupation _____
 Employer _____ Work phone _____ Cell phone _____
 Work address _____
STREET CITY STATE ZIP
 Primary Insurance _____ Phone _____
 Primary Insurance Address _____
STREET CITY STATE ZIP
 SSN or ID No. _____ Group No. _____ Date of birth _____
 Mother _____ Occupation _____
 Employer _____ Work phone _____ Cell phone _____
 Work address _____
STREET CITY STATE ZIP
 Secondary Insurance _____ Phone _____
 Secondary Insurance Address _____
STREET CITY STATE ZIP
 SSN or ID No. _____ Group No. _____ Date of birth _____
 Names and ages of other children in family _____

Medical History

Is your child in good health? Yes No
 Does your child have any history of major illness? Yes No
 Has your child ever been treated for an illness? Yes No
 Check any of the following for which your child has been treated:
 Diabetes Kidney involvement
 Pneumonia Tuberculosis
 Heart trouble AIDS
 Rheumatic fever Prolonged bleeding
 Bone disorder Fainting/dizziness
 Herpes Nervous disorders
 Anemia Liver involvement
 Epilepsy Endocrine problems
 Asthma Other: _____

Is your child prone to the following? Yes No
 Colds?
 Sore throats?
 Ear infections?

Have the tonsils/adenoids been removed? Yes No
 If so, at what age? _____

List any drugs/medications your child is taking and for what reasons: _____

List any allergy or drug sensitivity that your child has: _____

Has your child reached puberty? Yes No

Height _____ Weight _____

3306 Georgia Hwy 5
 Douglasville, GA 30135
P (770) 942.4100
F (770) 942.4945

4720-7 Jonesboro Rd
 Union City, GA 30291
P (770) 969-6444
F (770) 969-7008

Dental History

Have there been any injuries to your child's face/mouth/teeth? Yes No

Has your child ever sucked his/her thumb/fingers? Yes No
Until what age? _____

Does your child have any speech problems? Yes No

Is your child a mouth-breather?
While awake? Yes No
While asleep? Yes No

Does your child have any missing teeth? Yes No

Does your child have any extra permanent teeth? Yes No

Has an orthodontist been consulted? Yes No

Reason for consultation: _____

I have read and I understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form.

I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any later changes to this history record or medical/dental status.

We will discuss your child's treatment with parents/legal guardians/person(s) financially responsible for his/her treatment/referring doctor/dentist for the furtherment of his/her treatment.

Signature Date

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Signature Date

Medical History Updates or Changes

Date: _____

Comments: _____

Signature: _____

Date: _____

Comments: _____

Signature: _____

Date: _____

Comments: _____

Signature: _____

Thank you for filling out this form completely. It will enable us to provide you with better orthodontic care.