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 _____ Email _____

Employer _____ Work phone _____ Cell phone _____

Work address _____
STREET CITY STATE ZIP

Primary Insurance _____ Phone Number _____

Primary Insurance Address _____
STREET CITY STATE ZIP

SSN or ID No. _____ Group No. _____ Date of birth _____

Mother _____ Occupation _____ Email _____

Employer _____ Work phone _____ Cell phone _____

Work address _____
STREET CITY STATE ZIP

Secondary Insurance _____ Phone Number _____

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
- ○ Pneumonia
- ○ Heart trouble
- ○ Rheumatic fever
- ○ Bone disorder
- ○ Herpes
- ○ Anemia
- ○ Epilepsy
- ○ Asthma
- ○ Kidney involvement
- ○ Tuberculosis
- ○ AIDS/HIV
- ○ Prolonged bleeding
- ○ Fainting/dizziness
- ○ Nervous disorders
- ○ Liver involvement
- ○ Endocrine problems
- ○ Other:
- ○ If none of the above, please initial ____

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:_____

_____

_____

(If none, please write "None" in blank above, and initial.) ____

List any allergy or drug sensitivity that your child has:

_____

_____

(If none, please write "None" in blank above, and initial.) ____

Has your child reached puberty? ○ Yes ○ No

Height _____ Weight _____

7475 Douglas Blvd., Ste. 201
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? ○ Yes ○ No
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.