**CHILD**

Date:__________ Child's Name:__________ Age: ______

Date of Birth: ________ Gender: ____ School: __________ Grade: ______

Dentist: __________ Referred By: __________

Name of Parents or Guardian: __________ Relationship to child: __________

Address: __________ Email: __________

City: __________ State: ______ ZIP: ________ Home Phone: __________

**FATHER**

Name: __________ Social Security #: __________

Driver's Lic #: __________ Email: __________ Cell Phone: __________

Employed By: __________ Occupation: __________ Work Phone: __________

Work Address: __________ City: __________ State ______ ZIP______

**MOTHER**

Name: __________ Social Security #: __________

Driver's Lic #: __________ Email: __________ Cell Phone: __________

Employed By: __________ Occupation: __________ Work Phone: __________

Work Address: __________ City: __________ State ______ ZIP______

Do you have Orthodontic Insurance? ___ Yes ___ No If so, Company Name: __________

Address: __________ Group #: __________

City: __________ State: ______ ZIP: ________ Phone: __________

**MEDICAL HISTORY**

Physician's Name & Address: __________

Date of last physical exam: __________ Height: ________ Weight: ________

Have you or are you now under a physician's care for a health care problem? ___ Yes ___ No

If so, for what? __________

Have you been hospitalized in the last 5 years? ___ Yes ___ No If so, for what? __________

What medicines are you currently taking? __________

What operations have you had in the past? __________

Any known prescription drug allergies? __________

**PLEASE CHECK ANY OF THE FOLLOWING YOU HAVE HAD**

__ Allergies to penicillin
__ Allergies to local anesthesia
__ Allergies to food or drugs
__ Anemia
__ Fatigue easily
__ Prolonged bleeding from surgery
__ Heart problems
__ Chest pain
__ Swelling of ankles
__ Heart murmur

__ Stroke
__ High blood pressure
__ Low blood pressure
__ Lung disease
__ Asthma
__ Shortness of breath
__ Tuberculosis
__ Bloody cough
__ Headaches
__ Fainting or dizziness

__ Epilepsy
__ Sinus Problems
__ Neck pain or swelling
__ Difficulty swallowing
__ Thyroid problems
__ Visual problems (glasses?)
__ Frequent illness or infections
__ Tumors or growths
__ X-ray or cobalt therapy
__ Slow healing

__ Severe weight loss
__ Diabetes (sugar in blood)
__ Hepatitis (yellow jaundice)
__ Ulcers
__ Kidney problems
__ Steroid therapy (cortisone)
__ Drug dependence
__ Psychiatric care
__ Women: Are you pregnant?
__ Other physical condition