APDOrtho

ORTHODONTIC PATIENT INFORMATION AND HEALTH HISTORY FORM

In order to ensure that your child receives the best care at our practice, we ask you to carefully complete this form. This form is completely confidential and will be used only for dental records.

PATIENT INFORMATION AND HEALTH HISTORY

Child's Legal First and Last Name: _____ Child's Preferred Name: _____ Age: _____

Birthdate: _____ Sex:_____ Preferred Pronouns: _____ Home Telephone: _____

Child's Main Residential/Mailing Address (or P.O. Box): _____

City:_____ _____State: ____ Zip:_____

Guardian's Name: _____ Relationship to Child: _____

Cell: _____ Email: _____

Guardian 2's Name: _____ Relationship to Child: _____

Cell: _____ Email: _____

What is the best way to reach you? _____ What is the guardian's primary language? _____ The child's? _____

Emergency Contact Name: _____ Relationship to Child: _____ Phone: _____

Child's Physician/Pediatrician: _____ Phone: _____

Mailing Address: _____ City:_____ State: _____ Zip:_____

MEDICAL HISTORY

1. Is your child CURRENTLY taking any medications including prescription and/or non-prescription drugs or vitamins? Yes □ No □

Drug	How much & How often?	Reason

2. Has your child had any steroid treatment in the past 6 months? Yes □ No □

DENTAL PATIENT INFORMATION AND HEALTH HISTORY FORM

3. Does your child have any history of the following? (*Check all that apply*)

General conditions	***Developmental***	***Infectious***
☐ Arthritis	☐ Brain injury	☐ Hepatitis
☐ Asthma	☐ Cerebral palsy	☐ HIV infection (AIDS)
☐ Diabetes	☐ Cleft lip/palate	☐ Tuberculosis
☐ Gastrointestinal disorders	☐ Down Syndrome	☐ Sexually Transmitted Disease (STD)
☐ Heart disease	☐ Developmental delay	Type_____
☐ Heart murmur	☐ Feeding/Eating problems	
☐ Kidney disease	☐ Growth problems	***Substance use/Abuse***
☐ Rheumatic fever	☐ Hearing loss: Type _____	☐ Drug use
	☐ Eye problems:	☐ Tobacco use
Behavior/Learning	Type_____	☐ Exposure to smoking
☐ ADHD/ADD	☐ Neuromuscular defect	☐ Abuse (physical or sexual)
☐ Anxiousness/Nervousness	☐ Orthopedic problems	☐ Bullying
☐ Autism	☐ Seizures:	
☐ Behavior issues: Type_____	Type_____	***Other***
☐ Emotional problems:	☐ Speech problem:	☐ Cancer: Type _____
Type_____	Type_____	☐ Leukemia: Type _____
☐ Learning problems:	☐ Spina bifida	☐ Thyroid problem: Type _____
Type_____	***Hematological (Blood-related)***	☐ Fainting/headaches (often)
☐ Psychiatric disorder:	☐ Anemia	☐ Sleep apnea
Type_____	☐ Bleeding (prolonged)	☐ Sleep problems
	☐ Hemophilia	☐ Snoring
	☐ Sickle cell trait	☐ Syndrome: Type _____
	☐ Sickle cell disease	☐ Other: _____
	☐ Transfusion of blood	

4. Has your child had any known allergic reactions? Yes ☐ No ☐ If yes, please list (please include any food or drug allergy): _____

5. Does your child go to a special class or school? Yes ☐ No ☐ If yes, type: _____

6. Are your child's immunizations current? Yes ☐ No ☐ If no, why? _____

7. Have you ever been told that your child needs to take antibiotics before dental treatment? Yes ☐ No ☐

8. Has your child ever been hospitalized? Yes ☐ No ☐ If yes, reason for hospitalization(s): _____

9. Has your child had any surgery (operations)? Yes ☐ No ☐ For what reason(s): _____

10. Have you or your child ever felt threatened in your home or are there any elevated stresses happening in your home? Yes ☐ No ☐

11. Have your child's teeth ever been injured? Yes ☐ No ☐

12. Does your child have any of the following habits?

Thumb or finger sucking Yes ☐ No ☐ Mouth breathing Yes ☐ No ☐

Pacifier sucking Yes ☐ No ☐ Grinding of teeth Yes ☐ No ☐

---------- **FOR COMPLETION BY PATIENT/PATIENT REPRESENTATIVE** ----------

Patient/Parent/Guardian Signature	Name (printed):	Relationship to Patient or Patient	Date
_____	_____	_____	_____

---------- **FOR COMPLETION BY DENTIST** ----------

Dentist Signature: _____ **Print Name:** _____ **Date:** _____ **Time:** _____