

CHILD HISTORY FORM

Date _____

Confidential Patient Information

A B C

Patient's Name _____
Last First Middle

Address _____
Street City State zip

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Confidential Responsible Party Information

Name _____ Marital Status _____
Last First Middle

Residence _____
Street City State zip

Mailing Address _____
Street City State zip

How long at this address _____ Phone (H) _____ (C) _____ (W) _____
Contact at work Yes No

Email _____

Previous Address (if less than 3 yrs.) _____
Street City State zip

Social Security # _____ Birthday _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthday _____ Work Phone _____

Dental Insurance Information

Policy Holder's Name _____ and Soc.Sec. # _____

Insurance Company _____ Group No. _____ Union, Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Do you have dual coverage? No Yes If yes:

Policy Holder's Name _____ and Soc.Sec. # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship _____

Thank you for filling out both sides of this form.

CHILD DENTAL HISTORY

Has your child had previous orthodontic treatment? Yes No

Primary reason for today's visit: _____

Your child's dental health is: Good Fair Poor

Has your child experienced any problems with past dental work? Yes No

Has there been any injury/trauma to the teeth? Yes No

Explain: _____

Family dentist: _____

Address: _____

Phone#: _____

Does/did your child have any of the following habits?

- | | |
|---|---|
| <input type="checkbox"/> Lip sucking/biting | <input type="checkbox"/> Clenching/grinding teeth |
| <input type="checkbox"/> Speech problems | <input type="checkbox"/> Chewing on objects |
| <input type="checkbox"/> Mouth breathing | <input type="checkbox"/> Nursing bottle habits |
| <input type="checkbox"/> Thumb/finger sucking | <input type="checkbox"/> Used a pacifier |
| <input type="checkbox"/> Nail biting | <input type="checkbox"/> Tongue/cheek biting |
| <input type="checkbox"/> Tongue thrust | |

Allergic to any of the following?

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Dental anesthetics | <input type="checkbox"/> Metals/plastics | |

Please list any other drugs/materials that you are allergic to:

OFFICE USE

I have verbally reviewed the medical/dental information above with the patient named herein.

Staff initials: _____ Date: _____

Date: _____ Initials _____

Date: _____ Initials _____

Date: _____ Initials _____

Date: _____ Initials _____

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes. I understand that, where appropriate, credit bureau reports may be obtained.

Signature: (Parent's signature if minor) _____ Date: _____

**Wheaton
Orthodontic
Center**

David J. Allen, D.D.S., M.S., P.C.
116 W. Willow Ave. • Wheaton, IL 60187 • 630.668.0197
www.wheatonorthodontics.com

MEDICAL HISTORY

Child's physician: _____

Physician's phone#: _____

Is your child currently under the care of a physician? Yes No

Please explain: _____

Describe your child's current physical health: Good Fair Poor

Please list all drugs that your child is taking: _____

Has your child's tonsils/adenoids been removed? Yes No

Has your child had/experienced any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> AIDS/HIV+ | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hospital stays/operations |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Congenital heart defect | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Handicaps/disabilities | <input type="checkbox"/> Sickle cell anemia |
| <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Hepatitis | |

Do you wish to discuss anything with Dr. Allen in private? Yes No

Orthodontics for Adults and Children