



Patient Information

Name of Child _____ Nickname _____
Sex: M ___ F ___ Age ___ DOB _____ School _____ Grade _____
Home Address _____
Home Phone _____ Musical Instrument Played _____
Sports And /Or Hobbies _____
Names and ages of brothers and sisters _____
Whom may we thank for referring you _____

Parent's/Guardian's Information

Father's/Guardian's Name _____ Address (if different) _____ _____	Mother's/Guardian Name _____ Address (if different) _____ _____
Home Phone _____ Cell/Work # _____ Social Security # _____ Birth date _____ Employer _____ Address _____	Home Phone _____ Cell/Work # _____ Social Security # _____ Birth date _____ Employer _____ Address _____
Do you have dental insurance coverage? _____ Plan Name _____ Phone Number _____ Group # _____ Policy # _____	Do you have dental insurance coverage? _____ Plan Name _____ Phone Number _____ Group # _____ Policy # _____

Dental History

Name of Dentist _____
Date of last visit to your dentist _____ for what service _____
Does child brush teeth daily ___ Yes ___ No Does your child floss daily ___ Yes ___ No
Is fluoride taken in any form ___ Yes ___ No Periodontal Treatment ___ Yes ___ No
Clicking or popping of the jaw ___ Yes ___ No Grinding ___ Yes ___ No
Injuries to mouth, teeth or head ___ Yes ___ No Does your child follow directions well _____
Does your child currently chew or smoke tobacco ___ Yes ___ No
Orthodontic appliances worn now or ever ___ Yes ___ No
Any family member had/has orthodontia ___ Yes ___ No Relationship _____
Any unhappy dental experiences? _____
Does patient have any learning disabilities or need extra help with instructions? _____
Any mouth habits- thumb sucking, nail biting, mouth breathing, pacifier, sleeping with a bottle, etc.? _____

Please complete both sides

Medical History

Child's Physician _____ City/ State _____

Date of last physical examination _____ Results _____

Is child under care of physician now? Yes No Ever been hospitalized? Yes No

Ever had surgery? Yes No Is there excessive bleeding when cut? Yes No

Are there any other medical conditions we should be aware of? _____ If so please explain _____

GIRLS ONLY Has the patient started her monthly periods? _____ If so approximately when? _____

Is the patient pregnant? _____

Has your child had any history with any of the following? If yes, please mark with an x.

<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Drug/Alcohol Abuse	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Bladder Problems	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Fainting	<input type="checkbox"/> Measles	<input type="checkbox"/> Other
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Mononucleosis	
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Mumps	
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatic Fever	

Allergies or reactions to any of the following: If yes, please mark with an x.

<input type="checkbox"/> Local anesthetics (Novocaine or Lidocaine)	<input type="checkbox"/> Aspirin
<input type="checkbox"/> Ibuprofen (Motrin or Advil)	<input type="checkbox"/> Penicillin or other antibiotics
<input type="checkbox"/> Sulfa drugs	<input type="checkbox"/> Codeine or other narcotics
<input type="checkbox"/> Metals (jewelry, clothing snaps)	<input type="checkbox"/> Latex (gloves, balloons)
<input type="checkbox"/> Vinyl	<input type="checkbox"/> Acrylic
<input type="checkbox"/> Animals	

Foods _____ Other Substances _____

Is the patient taking medication, nutrient supplements, herbal or non-prescription medicine? Please name them.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

I hereby request that Dr. Charles M. Krowicki submit insurance forms on behalf of the above patient, and indicate on those forms that payment is to be made to the above named insured.

Signed: _____ Date Signed: _____

Parent or Guardian

Signed: _____ Date Signed: _____

Dental staff member