**CHILD**

**Patient Name** _____ Sex: M F
Last First Middle

Name Patient Prefers to be called _____ Date of Birth _____

Address _____ Home Phone _____
Street City Zip

School _____ Grade _____ Last Dental Visit _____

Patient's Dentist _____ Physician _____

Whom may we thank for referring you to us? _____

Do you plan to relocate out of the area in the near future? _____ If so, when? _____

Which office location is most convenient for you? Pensacola Pace Jay

**Father's Name** _____ Social Security # _____

Employer _____ Business Phone _____

Other Phone Number(s) Father can be reach at _____

**Mother's Name** _____ Social Security # _____

Employer _____ Business Phone _____

Other Phone Number(s) Mother can be reach at _____

Is the Patient under any medical treatment now? **YES** **NO** If so, what? _____

List any medications your child is currently taking _____

**List any drug allergies/sensitivities** _____

Is there a history of serious illness, accident, surgery, or other condition? _____

Has the Patient had any injury/trauma to his/her jaws? **YES** **NO** If so, what? _____

**Has the Patient had any of the following diseases or medical problems?**

Y N Head or Facial Injury
Y N Tonsillitis
Y N Hepatitis/Liver Disease
Y N Rheumatic Fever
Y N HIV/AIDS
Y N Kidney Disease
Y N Allergies or Asthma
Y N Metal Allergies

Y N Heart Murmur/Problems
Y N Arthritis
Y N Venereal Disease
Y N Epilepsy/Seizures
Y N Bleeding Problems
Y N Diabetes
Y N Ear Infections

Y N Cancer/Chemotherapy
Y N Hearing Disorder
Y N High Blood Pressure
Y N Emotional Problems
Y N Nervous Problems
Y N Endocrine Problems
Y N Jaw Joint Pain (TMJ)

Has the patient ever sucked a thumb or fingers? YES NO If so, until what age? _____

Have you been informed of any missing or extra permanent teeth? _____

Has an Orthodontist been consulted previously or has the patient had previous Orthodontic treatment? **YES** **NO**

If so, by whom? _____

What part of your child's Orthodontic problem concerns you most? _____

Additional information which you feel would make your child's experience with us more enjoyable _____

_____

The information that I have given today is correct to the best of my knowledge. I understand that this information will be held in strictest confidence and it is my responsibility to inform this office of any changes in the medical status of this patient.

Parent Signature _____ Date _____