

General Information

School _____

Brothers/Sisters
(include ages)

Hobbies

Medical History

Medical Physician? _____ Phone _____ Last Visit _____

Is the child currently under the care of a physician? Yes No If Yes, explain _____

Has puberty begun? Yes No Has menstruation (period) begun? Yes No N/A

Has the patient tonsils or adenoids been removed? Yes No

Has the patient ever experienced jaw joint pain/ discomfort (TMJ/TMD)? Yes No

Does the patient have any missing or extra permanent teeth? Yes No

Has the patient ever had an injury to : (select all that apply) Teeth Mouth Chin

Does/Has the patient ever had any of the following habits?	Lip Sucking/Biting	Nail biting	Prolonged Bottle/Pacifier
Clenching/Grinding Teeth	Mouth Breather	Tongue Thrusting	Thumb/ Finger Sucking

Does the patient have speech problems? Yes No If Yes, explain _____

Is the child allergic to any of the following?

Aspirin Erythromycin
Codeine Penicillin
Tetracycline Latex
Any Metals/Plastics

Other Allergies/Sensitivities:

List all drugs the Patient is currently taking

List any serious medical condition(s) treated

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.

I understand that where appropriate, credit bureau reports may be obtained.

Name of person filling out this form _____ Date _____