BERNHARDT & SMITH
ORTHODONTICS

CHILD HEALTH HISTORY FORM

Welcome to our office! Please help us serve your needs by completing this information sheet.

Date: _____

Patient's Name: _____
Last First Middle Nickname

Address: _____ City: _____ Zip: _____

Home Phone: _____

Sex: Male_____ Female_____ Age: _____ Birthdate: _____

Email: _____

School: _____ Grade: _____

Family Dentist: _____ Last Dental Visit: _____

Whom may we thank for referring your child to our office? _____

Have you or any other family members been treated by our office? _____ If so, who? _____

Reason for seeking orthodontic consultation? _____

Has your child ever been seen by another orthodontist? _____ If so, by whom and when? _____

_____

RESPONSIBLE PARTY INFORMATION

Parent/Guardian #1: _____
Last First Middle

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____

Social Security #: _____ Work Phone: _____

Do you have orthodontic insurance? _____ Insured's date of birth: _____

Parent/Guardian #2: _____
Last First Middle

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____

Social Security #: _____ Work Phone: _____

Do you have orthodontic insurance? _____ Insured's date of birth: _____

If you do have orthodontic insurance, we will need a copy of your insurance card.

**Please continue on the back of this page

MEDICAL HISTORY

Any Personal History of:

Heart Murmur	❒ Yes	❒ No	Allergy to Nickel or Latex	❒ Yes	❒ No
Heart Trouble	❒ Yes	❒ No	Arthritis, Rheumatism	❒ Yes	❒ No
Artificial Bones/Joints/Valves	❒ Yes	❒ No	Asthma, Hay Fever	❒ Yes	❒ No
Bleeding Problems	❒ Yes	❒ No	Anemia	❒ Yes	❒ No
Diabetes	❒ Yes	❒ No	Hepatitis	❒ Yes	❒ No
Kidney or Liver Involvement	❒ Yes	❒ No	High or Low Blood Pressure	❒ Yes	❒ No
AIDS/HIV +	❒ Yes	❒ No	Venereal Disease	❒ Yes	❒ No
Rheumatic Fever	❒ Yes	❒ No	Psychiatric Problems	❒ Yes	❒ No
Fainting Spells, Seizures	❒ Yes	❒ No	Female Patients Only:		
Tuberculosis, Lung Disease	❒ Yes	❒ No	Pregnant now?	❒ Yes	❒ No
Epilepsy or Convulsions	❒ Yes	❒ No	Has menstruation started?	❒ Yes	❒ No

History of Hospitalization? _____ Family Physician: _____

Please list any prescription/over-the-counter medications that your child is taking: _____

_____

Allergies, sensitivities or reactions to any medications? _____

Has your child ever had to take antibiotics before dental treatment? _____

Does your child have any disease, condition, or problem not listed above? _____

_____

DENTAL HISTORY

Oral Habits History:

Finger/Thumb Sucking	❒ Yes	❒ No	Nail Biting	❒ Yes	❒ No
Mouth Breathing	❒ Yes	❒ No	Lip/Tongue Biting	❒ Yes	❒ No
Smoke or Chew Tobacco	❒ Yes	❒ No	Clenching/Grinding Teeth	❒ Yes	❒ No

Any prior accidents to the mouth or teeth? _____ If yes, please explain: _____

Have tonsils and adenoids been removed? _____ If yes, at what age? _____

Does your child now have, or ever had any TMJ/jaw joint problems, such as popping, clicking, locking or pain?

_____

I have read and understand the above questions and affirm this information to be accurate. 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.

Signature: _____ Date: _____