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MEDICAL AND DENTAL INFORMATION
FOR MINOR CHILD

These questions are of great value in aiding us to a better understanding of your child.

Patient's Name LAST FIRST MIDDLE Nickname Sex

Date of Birth MO DAY YR Age in Years School Grade

Home Address NUMBER/STREET CITY ZIP Phone

Patient Resides With E-mail Address

Father's Name SS #

Work Phone Father's Cell #

Father's Occupation Employer How Long?

Mother's Name SS #

Work Phone Mother's Cell #

Mother's Occupation Employer How Long?

Person Responsible for Account/Relationship to Patient

Address (if different from above) STREET CITY STATE ZIP

Telephone and SS # (if different from above) HOME WORK SS #

Orthodontic Insurance? YES NO
If yes, Name of Insured Birth Date SS #

Name of Insurance Company

Address Phone

Whom may we thank for this referral?

MEDICAL HISTORY

The patient's Medical and Dental History Information is very important. This information bears directly on the outcome of treatment and is also important in helping to avoid complications. Thank you for taking the time to answer these questions.

1. Is patient in good health? YES NO

2. Name and address of patient's physician (Name) (City)

3. Patient's last physical examination was on

4. Is patient now under the care of a physician? YES NO

If so, what is the condition being treated?

5. Is patient taking any medicine(s), including non-prescription medicine? YES NO

If so, what medicine(s) is being taken?

6. Has patient had any serious illness, operation, or been hospitalized in the past 5 years? YES NO

If so, what was the the illness or problem?

7. Have tonsils and/or adenoids been removed? If yes, underline which, or both. YES NO

8. Has the patient had any other surgery. Please specify: YES NO

9. Has the patient had any injury to the face, head or teeth? YES NO

If yes, please indicate date(s) of occurrence and nature of injury:

10. Is patient adopted? YES NO
11. Does patient have, or has patient had, any of the following diseases or problems?
- a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease, scarlet fever, artificial joints? . . . YES NO
 - b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, arteriosclerosis, stroke) YES NO
 - c. High blood pressure YES NO
 - d. Low blood pressure. YES NO
 - e. Environmental allergies (hay fever, etc.) YES NO
 - f. Sinus trouble. YES NO
 - g. Asthma YES NO
 - h. Fainting spells or seizures, dizziness. YES NO
 - i. Diabetes YES NO
 - j. Hepatitis, jaundice or liver disease. YES NO
 - k. AIDS, HIV infection or positive HIV test YES NO
 - l. Thyroid problems YES NO
 - m. Respiratory problems, emphysema, bronchitis, etc. YES NO
 - n. Arthritis or painful swollen joints. YES NO
 - o. Stomach ulcer or hyperacidity YES NO
 - p. Kidney trouble. YES NO
 - q. Sexually transmitted disease YES NO
 - r. Epilepsy or other neurological disease. YES NO
12. Does patient have any blood disorder, such as anemia, hemophilia, leukemia, sickle cell disease? YES NO
13. Is patient allergic or has patient had a reaction to:
- a. Local anesthetics YES NO
 - b. Penicillin or other antibiotics YES NO
- Please specify _____
14. Has patient had any unfavorable experience in a dental or medical office? YES NO
- If so, explain _____
15. Does patient have any disease, condition, or problem not listed above that you think we should know about? YES NO
- If so, explain _____
16. Onset of puberty: (Boys - Voice changed); (Girls - started menstruation) YES NO

DENTAL INFORMATION

1. When was patient's last dental visit? _____
2. The name and address of patient's dentist is (Name) _____ (City) _____
3. I would describe patient's temperament as: _____
4. Patient's hobbies or sports interests are: _____
5. Does patient play a musical instrument? If so, what? _____ YES NO
6. Is patient a mouth breather? YES NO
7. Does patient have any history of thumbsucking, fingersucking, lip biting, nailbiting? YES NO
- Please underline and indicate Stopped or Continuing _____
8. Would patient mind wearing braces? YES NO
9. Has patient ever had orthodontic treatment (braces)? YES NO
10. Has patient ever had an orthodontic examination, evaluation, conference or consultation? YES NO
11. Has patient ever been told to see an orthodontist? YES NO
12. Will patient follow instructions regarding good oral hygiene? YES NO
13. Does patient's jaw joint(s) click, crack, pop, grate or make any other sound(s)? YES NO
14. Does patient grind or clench teeth? YES NO
15. Has patient's jaw ever "locked" open or closed? YES NO
16. Has patient ever been told that patient has a TMJ or "Jaw Joint" problem? YES NO

Please answer the following:

1. Present Height _____ Weight _____
2. Number of Brothers and Sisters _____ Have any of them received orthodontic treatment? YES NO
3. If we have previously seen another child in your family, please give the child's name(s) _____
4. In your own words, what is the problem? _____

The medical/dental information provided is complete and correct to the best of my knowledge. I agree to inform this office of any change(s). I understand that, where appropriate, credit bureau reports may be obtained. Thank you for your cooperation. The above information is important in your diagnosis and treatment, and will be kept in strict confidence.

Signed _____ Date _____
PARENT OR GUARDIAN