Welcome to our office!

Carlyle Orthodontics
Specializing in amazing smiles

Come smile with us!

## ***Tell Us About Your Child***

Today's Date: _____ Nickname: _____ Male Female

Child's Name: _____
Last First Middle

Birthdate: ___/___/___ Age: _____ Social Security #: _____

School: _____ Grade: _____

Hobbies/Sports: _____ Parent's Email Address: _____

Child's Home Phone #: _____

Child's Home Address: _____
Street City State Zip

Who is accompanying your child today? _____

Title: Mr. Mrs. Ms. Miss. Name: _____ Relationship: _____

Do you have legal custody of this child? Yes No Custodial Parent: _____

Whom may we thank for referring you to our office? _____

| List Siblings | Date of Birth | Age | Sex: M / F |
|---|---|---|---|
| | / / | | |
| | / / | | |
| | / / | | |
| | / / | | |

List any family members who have been or are in treatment in our office: _____

Parent's Marital Status: Single Partnered Divorced Married Separated Widowed

### ***Mother's Information***

Name: _____ Birthdate: ___/___/___ SS#: _____

Home#: _____ Work#: _____ Cell or Alternate#: _____

Employer: _____ Occupation: _____ Length of Service: _____

### ***Father's Information***

Name: _____ Birthdate: ___/___/___ SS#: _____

Home#: _____ Work#: _____ Cell or Alternate#: _____

Employer: _____ Occupation: _____ Length of Service: _____

### ***Stepmother/Guardian Information***

Name: _____ Birthdate: ___/___/___ SS#: _____

Home#: _____ Work#: _____ Cell or Alternate#: _____

Employer: _____ Occupation: _____ Length of Service: _____

### ***Stepfather/Guardian Information***

Name: _____ Birthdate: ___/___/___ SS#: _____

Home#: _____ Work#: _____ Cell or Alternate#: _____

Employer: _____ Occupation: _____ Length of Service: _____

Carlyle Orthodontics

What main concerns do you want to address with orthodontic treatment? _____

_____

Has your child ever been evaluated or had orthodontic treatment before? Yes No

Describe if yes: _____

Name of patient's general dentist: _____ Date of last dental visit: _____

Does your child need antibiotic premedication before dental procedures? Yes No

Has your child ever experienced any of the following?

Y N Clenching/Grinding Y N Nail Biting Y N Thumb/Finger Sucking

Y N Tongue Thrust Y N Nursing Bottle Habit Until what age? _____

Y N Lip Sucking/Biting Y N Speech Problems Y N Pacifier Habit

Y N Mouth Breathing Until what age? _____

Does your child experience frequent headaches? Yes No

Have there been any injuries to the face, mouth, teeth or chin? Yes No

Describe if yes: _____

List any musical instruments played: _____

Has your child been informed of any missing or extra permanent teeth? Yes No

Describe if yes: _____

Has your child had any pain/tenderness/noises in his/her jaw joint (TMJ/TMD)/ears, temples or cheeks? Yes No

Describe if yes: _____

**Has your child ever had any of the following medical problems?**

| | | | |
|---|---|---|---|
| Y N Abnormal Bleeding | Y N Cancer | Y N Heart Murmur/Heart Problems | Y N Rheumatic/Scarlet Fever |
| Y N ADD/ADHD | Y N Diabetes | Y N Hemophilia | Y N Tuberculosis |
| Y N Anemia | Y N Epilepsy/Convulsions | Y N Hepatitis/Jaundice | Y N Tonsillitis/Adenoiditis |
| Y N Arthritis | Y N Endocrine Problems | Y N Herpes | |
| Y N Artificial Joints/Valves | Y N Emotional Problems | Y N HIV/AIDS | Y N Tonsils Removed: |
| Y N Asthma | Y N Frequent Colds or Flu | Y N Kidney/Liver Problems | Age: _____ |
| Y N Blood Disease | Y N Handicaps/Disabilities | Y N Lupus | Y N Menarche Started: |
| Y N Bone Disorders | Y N Hearing Impairment | Y N Mitral Valve Prolapse | Age: _____ |

It answered yes to any above, please explain: _____

_____

Child's Physician: _____ Ph#: _____ Date Last Visit: _____

Is your child currently under the care of a Physician? Yes No

Describe if yes: _____

Please list all medications that your child is currently taking: _____

Please list all drugs/materials that your child is allergic or sensitive to: _____

**I understand that the information I have given 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 authorize the dental staff to perform the necessary dental services, including x-rays, my child may need.**

_____

**Signature of Parent or Guardian** **Date**

## HEALTH HISTORY UPDATES

| Date Reviewed | Reviewed By | List **ANY** Changes To This Form |
|---|---|---|
| | | |
| | | |