Oak Park Dentistry for Children & Orthodontics
A Professional Corporation

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Orthodontics and Dentofacial Orthopedics

PATIENT HISTORY - Child (Confidential)

Date _____

PATIENT INFORMATION

Patient's Name _____ Prefers to be called _____
Birthdate _____/_____/_____ Age _____ Sex _____
Address _____ City _____ State _____ Zip _____
Home Phone ( ) _____ Cell Phone ( ) _____ E-mail Address _____
If student, Name of School _____City _____ State _____
Sibling(s) Treated in this Office _____
Person to Contact in Case of Emergency_____ Phone ( ) _____
Parents' Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐
Parent #1 Name _____ Home Phone ( ) _____ Cell Phone ( ) _____
Address _____ City _____ State _____ Zip _____
Occupation _____ Work Phone ( )_____
Parent #2 Name _____ Home Phone ( ) _____ Cell Phone ( ) _____
Address _____ City _____ State _____ Zip _____
Occupation _____ Work Phone ( )_____
Whom May We Thank For Referring You to Our Office? _____

PERSON RESPONSIBLE FOR THIS ACCOUNT

First Name _____ MI _____ Last Name _____
Address _____ City _____ State _____ Zip _____
Occupation _____
Home Phone ( ) _____ Cell Phone ( ) _____
Employer _____ Social Security # _____
Business Address _____ City _____ State _____ Zip _____
Relationship to Patient (Please check one) Parent ☐ Step Parent ☐ Legal Guardian ☐ Other ☐
Person Responsible for Making Appointments: Name _____ Phone ( ) _____

ORTHODONTIC INSURANCE INFORMATION

Name of Insurance Company _____Policy # _____
Address _____ City _____ State _____ Zip _____
Policy Owner _____ Social Security # / ID #_____ Birthdate _____/_____/_____
Subscriber Relationship to Patient_____ Insurance Co. Phone ( )_____

PERSONAL INFORMATION

What is the main problem as you see it? _____
Has anyone in the family received orthodontic treatment? _____ Who? _____
How would you describe your child's temperament? _____
Is your child sensitive about the appearance of his/her teeth? _____
How does your child feel about wearing braces? _____
Patient's hobbies or interests _____

MEDICAL

Physician's Name _____ Approximate date of last medical examination _____

PLEASE CIRCLE IF APPLICABLE NOW OR IN THE PAST, AND EXPLAIN BELOW.

Y/N		Y/N		Y/N		Y/N	
☐☐	ever been hospitalized	☐☐	tonsils removed	☐☐	prolonged bleeding	☐☐	mouth breathing
☐☐	taking medication	☐☐	adenoids removed	☐☐	diabetes	☐☐	snores when sleeping
☐☐	allergic to medication	☐☐	rheumatic fever	☐☐	epilepsy	☐☐	sounds "stuffy"
☐☐	asthma	☐☐	heart disease	☐☐	hormone therapy	☐☐	frequent sore throats
☐☐	other allergies	☐☐	heart murmur	☐☐	emotional problem	☐☐	abnormal growth problems
☐☐	hepatitis	☐☐	anemia	☐☐	arthritis		

Updated

PLEASE EXPLAIN: _____

_____

_____

PLEASE LIST ANY MEDICATIONS YOUR CHILD IS CURRENTLY TAKING:

_____

_____

_____

GENETIC

	YES	NO
Is the patient adopted?	○	◉
If so, does the patient know this?	○	○
Has any member of the family had:		
A similar orthodontic condition?	○	○
A similar facial appearance?	○	○
A history of early or late puberty changes?	○	○

PLEASE EXPLAIN:

_____

_____

_____

DENTAL

Dentist's Name _____ Approximate date of last dental examination _____

PLEASE CIRCLE IF APPLICABLE NOW OR IN THE PAST, AND EXPLAIN BELOW.

Y/N		Y/N		Y/N	
☐☐	apprehensive about dental care	☐☐	speech therapy	☐☐	jaw joint pain
☐☐	discomfort from teeth	☐☐	injury involving teeth	☐☐	jaw "tires" at mealtime
☐☐	discomfort from gums	☐☐	injury to either jaw	☐☐	jaw catches when opening
☐☐	previous orthodontic therapy	☐☐	frequent clenching of teeth	☐☐	jaw locks in closed position
☐☐	frequent canker sores	☐☐	wake up with sore teeth	☐☐	facial pain
☐☐	previous thumb/finger sucking	☐☐	wake up with sore jaw	☐☐	frequent headaches
☐☐	thumb/finger presently active	☐☐	jaw joint sounds	☐☐	neck or shoulder pain

PLEASE EXPLAIN: _____

_____

_____

Signature of Parent or Guardian _____ Date _____