

Patient Name \_\_\_\_\_

For the following questions mark yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential.

### CHILD PATIENT PROFILE

- Does the patient follow directions well?  Yes  No  dk/u  
Does the patient brush his/her teeth well?  Yes  No  dk/u  
Is the patient sensitive or self-conscious about his/her teeth?  Yes  No  dk/u

### DENTAL HISTORY

- Please indicate your main concerns \_\_\_\_\_  
Date of your last dental examination \_\_\_\_\_  
Has the patient ever had orthodontic treatment?  Yes  No  dk/u  
Has an orthodontist been previously consulted?  Yes  No  dk/u  
Has the patient had any periodontal or gum problems?  Yes  No  dk/u  
Is the patient having pain or discomfort at this time?  Yes  No  dk/u  
Have there been injuries to the face, mouth, or teeth?  Yes  No  dk/u  
Have you been informed of any missing or extra permanent teeth?  Yes  No  dk/u  
Does the patient have any of the following habits?  
 Clenching/Grinding  Thumb/Finger Sucking  Tongue Thrust  Mouth Breathing  
What concerns you most about orthodontic treatment?  
 Appearance of appliances  Cost  Length of time  Discomfort  Results  Other \_\_\_\_\_

### MEDICAL HISTORY

- Please describe the patient's current health:  Good  Fair  Poor  
Please list all medications the patient is currently taking \_\_\_\_\_  
Is the patient allergic to any drugs or medications? Please list \_\_\_\_\_  
Has the patient ever had any of the following conditions? (please circle)

- |                          |                    |                       |
|--------------------------|--------------------|-----------------------|
| Heart Disease            | Asthma             | Epilepsy or Seizures  |
| High Blood Pressure      | Diabetes           | Sleep Apnea           |
| Heart Surgery            | Thyroid Disease    | Bone Disorders        |
| Heart Murmur             | Sinus Trouble      | Growth Disorders      |
| Rheumatic Fever          | Pain in Jaw Joints | Allergies to Latex    |
| Congenital Heart Lesions | Cancer             | Allergies to Metals   |
| Artificial Heart Valve   | HIV/AIDS           | Allergies to Plastics |
| Artificial Joint         | Hepatitis          |                       |
| Stroke                   | Bleeding Disorder  |                       |

Does the patient have any disease, condition, or problem not listed? Please list \_\_\_\_\_

WOMEN: If patient is an adolescent, has menstruation begun?  Yes  No  
If yes, are what age? \_\_\_\_\_

To the best of my knowledge, all of the preceding answers are true and correct. If there are any changes in health, I will inform the office at the next appointment without fail.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian