

Patient Number: _____

Date: _____



CHILD/ADOLESCENT ORTHODONTIC CONSULTATION

Patient's Name: _____

Age: _____ Date of Birth _____

Home Phone: _____

Address: _____

Mother's Name: _____

Mother's Cell.Phone _____ Mother's Email: _____

Mother's Bus.Phone: _____ Mother's Occupation: _____ Mother's Employer _____

Father's Name: _____

Father's Cell.Phone _____ Father's Email: _____

Father's Bus.Phone: _____ Father's Occupation: _____ Father's Employer _____

Parent's Marital Status: _____

Who will be responsible for this account? _____

In your own words, what is the problem? _____

MEDICAL HISTORY

Name of child's physician: _____

Address of physician: _____ Phone: _____

Date of last examination: _____

3E Courtyard Plaza
 Leeward Highway
 Providenciales, Turks and Caicos Islands
 Tel No: 649-941-2220; Fax: 649-941-2221; Mobile: 649-242-4609
 Email: smiletci649@gmail.com
 Website: SmileTingrinner.com

Is your child in good health?**Yes No Don't know**

Does your child have a health problem?**Yes No Don't know**

If "yes" explain: _____

Has your child ever been hospitalized, had general anesthesia, or emergency room visits?

Yes No Don't know

If "yes" explain: _____

Are your child's immunizations up to date?**Yes No Don't know**

Allergies (Please list) _____

Past medication taken by child: _____

Daily medication child is now taking: _____

Has your child ever had or been treated by a physician for: (Please circle your response)

Problems at Birth? **Yes No Don't know**

Diabetes? **Yes No Don't know**

Heart murmur? **Yes No Don't know**

Arthritis? **Yes No Don't know**

Heart Disease? **Yes No Don't know**

Cancer? **Yes No Don't know**

Rheumatic Fever? **Yes No Don't know**

Cerebral Palsy? **Yes No Don't know**

Anaemia? **Yes No Don't know**

Seizures? **Yes No Don't know**

Sickle Cell Anaemia? **Yes No Don't know**

Asthma? **Yes No Don't know**

Bleeding/Haemophilia? **Yes No Don't know**

Cleft Palate/Lip? **Yes No Don't know**

Tonsil/Adenoid Problems? **Yes No Don't know**

Speech/Hearing Problems? **Yes No Don't know**

Transfusion?	Yes	No	Don't know
Hepatitis?	Yes	No	Don't know
AIDS/HIV?	Yes	No	Don't know
Skin Problems?	Yes	No	Don't know
Tuberculosis?	Yes	No	Don't know
Sleep Problems?	Yes	No	Don't know
Liver Disease?	Yes	No	Don't know
Kidney Problems?	Yes	No	Don't know
Emotional/Behaviour Problems? ...	Yes	No	Don't know
Eye Problems?	Yes	No	Don't know

If "yes" to any of the above questions, please explain this or any other problem:

Has your child had any recent rapid growth? _____

If so, how much? _____

PARENTS: Father (Height) _____ (Weight) _____

Mother (Height) _____ (Weight) _____

SIBLINGS: 1. (Height) _____ (Weight) _____

2. (Height) _____ (Weight) _____

FEMALES: Has menstruation begun? **Yes No**

If yes, when? _____

Pregnant? ... **Yes No**

DENTAL HISTORY

Has your child seen a Dentist before? _____

Date of last visit: _____

Regular Dentist's name: _____

- Has your child ever experienced any complications following dental treatment?

Yes No Don't know

- Has your child had cavities and/or toothaches? **Yes No Don't know**

- Are your child's teeth sensitive to temperature or food? **Yes No Don't know**

- Did your child ever get instruction on brushing? **Yes No Don't know**

- Do your child's gums bleed when brushing? **Yes No Don't know**

- Does your child use fluoride products - Rinse, Drops? **Yes No Don't know**

- Has your child had any clicking or pain in the jaw joints? **Yes No Don't know**

If "yes" - Explain: _____

- Has your child inherited any family or dental characteristics? **Yes No Don't know**

If "yes" - Explain: _____

- Has your child ever injured his/her teeth? **Yes No Don't know**
- Did your child use a pacifier/soother? **Yes No Don't know**
- Did your child suck a finger or thumb? **Yes No Don't know**
- Has your child ever had dental x-rays? **Yes No Don't know**

Date: _____

Does your child have any other dental problem(s) we should know about?

Child's School: _____

Child's Grade in School: _____

Do you consider your child to be: (Check one [1])

Advanced in learning _____

Progressing normally _____

Slow learner _____

Will your child be uncooperative? **Yes No Don't know**

If "yes" -Explain: _____

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

Person completing this form: _____

Relationship with patient: _____