

CHILD INFORMATION SHEET

Full name _____ Nickname _____ Gender: _____ Age _____

Address: _____ Phone# _____ Birthdate: _____
_____ Dentist: _____ Physician: _____

Mother's Name: _____ Father's Name: _____
Address: _____ Address: _____

Phone #'s H _____ W _____ Phone #'s H _____ W _____
Cell _____ Cell _____

Occupation: _____ Occupation: _____
Email: _____ Email: _____

Siblings names and ages: _____

Age of onset of menstruation in girls or voice change in boys: _____

Does your child have any of these habits? (Please circle) Thumb/finger sucking Tongue thrust
Lip sucking Mouth breathing Teeth clenching/grinding

Is your child in good health? _____ Is your child nervous about today's appointment? _____

Describe any trauma to the face, teeth or jaws: _____

Does your child need antibiotics for dental procedures? _____ Dose: _____

List medications taken regularly: _____

List allergies your child has: (drugs, metals, plastics, latex, etc.) _____

Describe special needs your child has: _____

Anything else you think we should know? _____

Please circle any conditions your child has had and describe below:

- | | | |
|----------------------|---------------|---------------------|
| Asthma | Bone disorder | Bleeding disorder |
| Cancer | Diabetes | Heart murmur/defect |
| Hepatitis | HIV or AIDS | Hospitalizations |
| Kidney/liver disease | Seizures | Surgery |

Describe: _____

How often does your child brush? _____ Floss? _____

When did your child last have bitewing x-rays? _____

Does your child gag easily? _____

What is your main concern about your child's teeth? _____

Please describe any previous orthodontia: _____

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

If you have orthodontic insurance, please fill out the reverse side of this form.

Parent/Guardian: _____ Date: _____