Eastside orthodontics
Courtney Martusiewicz DDS MS

Child Health History Form

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Patient Information

Name ______ Date of Birth ______ Age ______

Address ______ City ______ State ______ Zip ______

Parent's Preferred Phone ______ Work # ______

School ______ Grade ______

Sports, Hobbies, etc. ______

Names and Ages of Siblings ______

Referred to Our Office By ______

Family Dentist ______ Phone ______ Address ______

Family members who have had orthodontic treatment ______

Have you seen another orthodontist? ______ Name ______

Responsible Party Information

Father's Name ______ Date of Birth ______

Mother's Name ______ Date of Birth ______

Married ______ Divorced ______ Separated ______ Remarried ______ Remarried ______

Father Deceased ______ Mother Deceased ______ Child Lives With ______

Whose name should be listed as the Responsible Party or Guardian? ______

Address ______ City ______ State ______ Zip ______

Cell Phone ______ Email ______

Occupation ______ Date of Birth ______ Social Sec # ______

Dental Insurance Information

Primary Insured's Name ______

Address ______ City ______ State ______ Zip ______

Cell Phone ______ Email ______

Employer ______ Address ______

Occupation ______ Date of Birth ______ Social Sec # ______

Dental Insurance Co. ______ Group # ______ ID# ______

Insurance Co Address ______ Phone ______

Secondary Insured's Name ______

Address ______ City ______ State ______ Zip ______

Cell Phone ______ Email ______

Employer ______ Address ______

Occupation ______ Date of Birth ______ Social Sec # ______

Dental Insurance Co. ______ Group # ______ ID# ______

Insurance Co Address ______ Phone ______

Medical History

General Health ____Poor ____Fair ____Good ____Excellent Do you need to premedicate for dental work? ____Yes ____No

Birth Defects ____________________

Presently under medical care for ____________________

Drugs or medication being taken now (Drug and Dosage) ____________________

Please list any allergies ____________________

Have you had any surgeries or been hospitalized? ____________________

PLEASE CHECK YES OR NO TO THE FOLLOWING AND DATE

	Yes	No		Yes	No		Yes	No
ADHD	___	___	Diabetes	___	___	Kidney disorder	___	___
AIDS	___	___	Dizziness	___	___	Liver disorder	___	___
Allergies	___	___	Emotional	___	___	Lung disorder	___	___
Anemia	___	___	Endocrine disorder	___	___	Measles/Mumps	___	___
Arthritis	___	___	Epilepsy	___	___	Neurosis	___	___
Asthma	___	___	Eye disorder	___	___	Nosebleeds	___	___
Autism	___	___	Fainting Spells	___	___	Rheumatic fever	___	___
Blood disorder	___	___	Hearing difficulties	___	___	Scoliosis	___	___
Bone disorder	___	___	Heart disorder	___	___	Seizures	___	___
Breathing difficulties	___	___	Hepatitis	___	___	Speech difficulties	___	___
Bronchitis	___	___	Hospitalized	___	___	Tonsils/Adenoids (removed)	___	___
Cancer	___	___	Hyperactivity	___	___	Tuberculosis	___	___
Cerebral palsy	___	___	Hypertension	___	___	Venereal Disease	___	___
Congenial heart disease	___	___	Injuries	___	___	X-ray treatment	___	___
Convulsions	___	___	Jaundice	___	___			

Other ____________________

Please give greater details where necessary ____________________

____

Female patients only: Monthly periods ____Yes ____No Started at age: ______Years ______ months

Is the patient pregnant? ____ Yes ____ No

Dental History

Date of last dental check up ____________ Does your water contain fluoride? ____Yes ____No

Injuries or trauma to the face or teeth? ____________________

Brushing teeth: Several times a day ______ Once a day ______ Nearly every day ______ Rarely ______

Does the patient play a musical instrument? ____________________

Thumb sucking ____Yes ____No Discontinued at age ______ Other habits ____________

Breathing: Nose ______ Mouth ______ Difficulty at night ____________

Mouth: Usually open ______ Frequently open ______ Seldom open ______

Infections: None _____ Ear_____ Nose _____ Throat _____ Speech: Difficulty in pronunciation ____Yes ____No

Speech lessons ____Yes ____No Bruxism: Grinds teeth ____Yes ____No at night ______ daytime ______

Why are you seeking orthodontic treatment? ____________________

Questionnaire completed by ____________________ Relation to patient ____________