

**CHILD MEDICAL HISTORY FORM**

Date: \_\_\_\_\_

Patient's Name \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Age: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

School Attending: \_\_\_\_\_ Grade \_\_\_\_\_ Referred to Dr. Hutta by: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Occupation: \_\_\_\_\_

E-mail: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Occupation: \_\_\_\_\_

E-mail: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Person Responsible for Financial Obligation: \_\_\_\_\_ SS# \_\_\_\_\_

Who will bring child to appointments? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Is Orthodontic Treatment covered by your insurance? Yes/No

Name of Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ Group # \_\_\_\_\_

PATIENT'S DENTIST: \_\_\_\_\_ PATIENT'S PHYSICIAN: \_\_\_\_\_

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***DENTAL HISTORY***

Date of last dental check-up: \_\_\_\_\_ Any Facial/Dental Injuries? Yes/No

Please describe: \_\_\_\_\_

Any baby or permanent teeth removed by your dentist? \_\_\_\_\_

Thumb, finger sucking, or pacifier habit? Yes / No Until age: \_\_\_\_\_

Any difficulty breathing through nose (awake / sleep): \_\_\_\_\_

Any tooth clenching/grinding? Yes / No

Any clicking or pain when opening/closing the mouth? Yes / No

Any speech problems? \_\_\_\_\_  
\_\_\_\_\_

Is pre-medication needed with antibiotic before dental visits? Yes / No

(please turn over)

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***MEDICAL HISTORY***

Is the patient currently under the care of a physician? Yes / No If so, why: \_\_\_\_\_  
\_\_\_\_\_

Is the patient taking any medication now? Yes / No If so, what kind? \_\_\_\_\_  
\_\_\_\_\_

Any allergies or drug sensitivity? Yes / No If so, what? \_\_\_\_\_

Have tonsils/adenoids been removed? Yes / No At what age: \_\_\_\_\_

Please describe any present or past medical problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Hospitalizations and operations: \_\_\_\_\_  
\_\_\_\_\_

Has patient reached puberty: Yes / No Girls; menstruation? Y / N Boys: has voice changed? Y / N

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I understand that the information I have given here today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical history. I authorize the dental staff to perform any necessary dental services with my informed consent that my child may need during diagnosis and treatment. Records can be released for a fee of \$200.00. I understand that where appropriate credit reports may be obtained.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Today's Date

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***FOR OFFICE USE ONLY***

Told:      TTM              TTD              NPP              PT              TTM&D