Child

Name:_____

Williams ORTHODONTICS
Your smile is our specialty

Medical and Dental History Information

Please circle any of the following which the patient has had or presently has:

Heart Disease	Rheumatic Fever	Thyroid Disorder	Hepatitis
High Blood Pressure	Growth Disorders	Diabetes	HIV or AIDS
Heart Surgery	Sleep Apnea	Cancer	Cold Sores
Heart Murmur	Asthma	Stroke	Allergies to Latex
Congenital Heart Problems	Blood Disorders	ADHD	Allergies to Metals
Artificial Heart Valve	Bleeding Disorder	Autism	Allergies to Plastics
Rheumatism	Anemia	Epilepsy/Seizures	Pain/Noise in Jaw Joint
Artificial Joint	Bone Disorders	Fainting/Dizzy Spells	

Please describe the patient's current health: Good ☐ Fair ☐ Poor ☐

Does the patient have any disease or condition not listed? If so, please list:_____

Has the patient taken any medications in the last two years? If so, please list:_____

Is the patient allergic to any drugs or medications? If so, please list: _____

Please indicate your main concerns: _____

Has the patient ever been treated by an orthodontist or seen an orthodontist for a consultation? Yes ☐ No ☐

What concerns you the most about orthodontic treatment? Appearance of appliances ☐ Cost ☐ Length of time ☐ Discomfort ☐ Results ☐

If you could change anything about the appearance of your teeth or smile, would you do so? _____ Yes ☐ No ☐

What would you change?_____

What is the patient's attitude toward braces? Eager ☐ Willing ☐ Indifferent ☐ Resigned ☐ Opposed ☐

Does the patient follow directions well? _____ Yes ☐ No ☐

Does the patient brush his/her teeth well? _____ Yes ☐ No ☐

Is the patient self-conscience about his/her teeth? _____ Yes ☐ No ☐

Has the patient had any periodontal or gum problems?_____ Yes ☐ No ☐

Is the patient having any pain or discomfort? _____ Yes ☐ No ☐

Have there been injuries to the face, mouth, or teeth? _____ Yes ☐ No ☐

Have you been informed of missing or extra permanent teeth?_____ Yes ☐ No ☐

Does/did the patient ever suck a thumb, lip, or tongue? _____ Yes ☐ No ☐

Does the patient grind or clench his/her teeth at night?_____ Yes ☐ No ☐

Does the patient snore at night? _____ Yes ☐ No ☐

Does the patient frequently breathe through his/her mouth and have an open mouth posture?_____ Yes ☐ No ☐

Has the patient had his/her tonsils/adenoids removed? _____ Yes ☐ No ☐

MALE PATIENTS: Has his voice begun to change? (this relates to jaw growth) Yes ☐ No ☐ Has he started to shave? Yes ☐ No ☐

FEMALE PATIENTS: Has she started her monthly period? (this relates to jaw growth) Yes ☐ No ☐ If so, at what age? _____

Do you realize that it is necessary to schedule some orthodontic appointments during school hours? Yes ☐ No ☐

To the best of my knowledge, these answers are true & correct. I will inform the office with any changes in health/medication.

Parent/Guardian Signature: _____ **Date:** _____