



OFFICE USE ONLY	
Exam Date _____	_____
Office: BM _____	MILF _____
Computer# _____	_____

CHILD PATIENT HISTORY

GENERAL INFORMATION:

Name _____ Birthdate _____ Age _____ Male _____ Female _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Employer (if any) _____ Work Phone _____
 EMail _____ School _____ Grade _____ Graduation Date _____
 Please list the names and birthdates of all brothers and sisters _____
 Persons to contact in case of emergency _____
 Name _____ Relation to you _____ Phone _____
 Name _____ Relation to you _____ Phone _____

PARENT INFORMATION:

Father's Name _____ Occupation _____ SS# _____ DOB _____
 Employer _____ City _____ State _____ Phone _____
 Mother's Name _____ Occupation _____ SS# _____ DOB _____
 Employer _____ City _____ State _____ Phone _____
 Marital Status of Biological Parents: Single _____ Married _____ Divorced _____ Widowed _____
 Responsible Party to Pay _____
 Address (if not the same) _____ Phone _____

MEDICAL HISTORY:

Physician _____ Address _____
 Patient's General Health: Good ___ Fair ___ Poor ___ Is the patient presently under a physician's care? _____
 Is the patient taking any medication? _____ If so, what? _____
 Is the patient allergic to or had an unusual reaction to any medication? _____
 Has the patient ever had any major operations? _____
 Has the patient ever had a serious accident involving head injuries? _____
 Has the patient ever had an accident involving whiplash? _____
 Any history of mental illness? _____
 Height _____ Weight _____ Has patient reached puberty? _____ / Date: _____
 Have tonsils or adenoids been removed? _____ If so, at what age? _____
 Frequent colds, sore throats, or ear infections? _____ Frequent breathing problems (congestion)? _____
 Any hearing problems? _____ Does patient snore? _____
 Any speech problems? _____ Speech therapy? _____
 Has the patient been diagnosed or treated for any of the following: HIV+ ___ Asthma ___ Arthritis ___ Anemia ___ ADD ___
 Diabetes ___ Epilepsy ___ Heart ___ Emotional ___ Endocrine ___ Rheumatic Fever ___ Speech Problems ___ ADHD ___
 Scoliosis ___ Stomach or Intestinal Disease ___ Learning Disabilities ___ Hyperactivity ___ High Blood Pressure ___
 Tumors or Growths ___ Blood Disease ___ Yellow Jaundice or Hepatitis ___ TB ___ Other _____
 If you answered yes to any of the above questions, please explain _____

 Is the patient allergic to any known materials resulting in hives, asthma, eczema, etc? _____
 Have any wounds healed slowly or presented other complications? _____
 Does the patient have a headache more than once a week? _____
 Is the patient bothered by chronic neck, shoulder, or jaw pain? _____
 Does the patient hear clicking or popping in their jaw joint area? _____

DENTAL HISTORY:

Dentist _____ Location _____

Last exam? _____

Have there been any injuries to the mouth or teeth? _____

Has the patient ever sucked their fingers or thumb? _____ To what age? _____

Is the patient a mouth breather while asleep or awake? _____

Does the patient have any missing or extra permanent teeth? _____

Have the wisdom teeth been extracted? _____

Does the patient have difficulty chewing or swallowing? _____

Do the patient's gums bleed while brushing or flossing? _____

How many times per month does the patient floss? _____

Are you aware of any tooth grinding or clenching? _____ Day or night? _____

Has the patient ever had instructions on how to brush their teeth? _____

Has the patient had instructions on how to care for gums? _____

Does the patient chew on only one side of their mouth? _____ If so why? _____

Does the patient experience any soreness or sensitivity in their mouth? (cold, hot, sweet foods, etc.) _____ If yes, locate _____

Has the patient ever been diagnosed as having periodontal disease? _____

When was the last full mouth XRAY taken? _____ Where? _____

What are you or your dentist most concerned about? _____

What concerns you most about the thought of braces? Appearance ___ Cost ___ Pain ___ Length of time ___ Will it work ___

Other _____

Has anyone in the family had orthodontic treatment? _____

If yes, was Dr. Wolterman their orthodontist? Yes _____ No _____

If yes, please write the patient's name here _____

Were you aware of any ortho problems prior to the referral? Yes ___ No ___ If so what: _____

Please name everyone we can thank for you being here _____

FINANCIAL ARRANGEMENTS DETERMINED BY CREDIT APPROVAL

PLEASE HAVE CHILD/PATIENT COMPLETE THE FOLLOWING

Do you have a nickname? _____ If so, what? _____

What is your favorite school subject? _____

What is your least favorite school subject? _____

What is the name of your favorite music group or song? _____

What is your favorite book, movie and /or TV show? _____

Do you participate in any sports? _____ What are your favorite sports? _____

Do you have any pets? _____ If so, what kind and their names: _____

Do you have any hobbies or collect anything? _____ If so, what? _____

Which of your friends come to our office also? _____