

Darlene M. Byrd, D.D.S., M.S.D.

Orthodontics

PATIENT HISTORY FORM – CHILD

Name: _____

Age: _____ Sex: _____ Birthdate: _____

Address: _____

Home Phone: () _____

School: _____ Grade: _____

Other family members treated here: _____

Parent or Guardian #1: _____

Marital Status: _____

Address: _____

Home Phone: () _____

Employer: _____ Position: _____

Work Phone: () _____

Parent or Guardian #2: _____

Marital Status: _____

Address: _____

Home Phone: () _____

Employer: _____ Position: _____

Work Phone: () _____

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

What is your main concern about the patient's teeth? _____

DENTAL HISTORY:

Dentist: _____

Phone: () _____

Address: _____

Date of last exam: _____

How many times a day does your child brush his/her teeth? _____

Date of last X-ray: _____

Has anyone in the family had orthodontic treatment? _____

Habits? Thumb: _____ Nails: _____ Tongue: _____ Other: _____ Mouth Breather: _____ Yes _____ No _____

Has the patient ever had?

Clicking of the jaw Yes _____ No _____

Pain (joint, ear, face) Yes _____ No _____

Difficulty opening or closing Yes _____ No _____

Difficulty chewing Yes _____ No _____

Speech problems Yes _____ No _____

Missing or extra teeth Yes _____ No _____

Learning disabilities Yes _____ No _____

Trauma or injury to teeth/face Yes _____ No _____

Date of onset of menstruation (if applicable): _____

MEDICAL HISTORY:

Physician: _____

Phone: () _____

Anemia Yes _____ No _____

Kidney involvement Yes _____ No _____

Arthritis or joint disease Yes _____ No _____

Liver disease Yes _____ No _____

Asthma Yes _____ No _____

Nervousness Yes _____ No _____

Bone disorders Yes _____ No _____

Prolonged bleeding Yes _____ No _____

Cancer Yes _____ No _____

Respiratory disorders Yes _____ No _____

Dizziness Yes _____ No _____

Rheumatic fever Yes _____ No _____

Epilepsy Yes _____ No _____

Tuberculosis Yes _____ No _____

Fainting Yes _____ No _____

Venereal disease Yes _____ No _____

Head and neck pain Yes _____ No _____

Herpes II, AIDS or Positive HIV status Yes _____ No _____

Heart disease Yes _____ No _____

Hypertension Yes _____ No _____

Have the tonsils and adenoids been removed? What age? _____

List all drugs or medication now being taken: _____

List allergies: _____

Any other medical considerations: _____

GUARANTOR: (Person financially responsible for the patient's account)

Name: _____ Relation to patient: _____ Home Phone: () _____

Address: _____ Work Phone: () _____

E-mail Address: _____

PERSON TO CONTACT REGARDING SCHEDULING _____ Phone: () _____

I, the undersigned, have given the above dental and medical information, have reviewed it and find it accurate. If there are any later changes to the history record, I will so inform the practice. I also authorize Dr. Darlene Byrd to perform an orthodontic examination.

Signature: _____ Date: _____

Responsible Party

Reviewed by: _____