SHANNON
ORTHODONTICS

Child History Form Date _____

Patient name_____
Sex _____ Age_____ Birth date_____ Home phone # _____
Address_____
Cell phone # _____ School_____ Grade_____
Are parents married? Yes or No If no, patient lives with: Mom Dad Other
Names of siblings with ages _____
Who will bring patient to most appointments? _____

Mother's name_____ Cell phone # _____
Occupation_____ Employer_____
Work phone # _____ Best number to be contacted at _____
Orthodontic insurance_____ Birth date _____
SS#_____ Email _____

Father's name_____ Cell phone # _____
Occupation_____ Employer_____
Work phone # _____ Best number to be contacted at _____
Orthodontic insurance_____ Birth date _____
SS#_____ Email _____

Who referred you to our office? _____
Family members we have seen _____
Dentist_____ Date of last cleaning_____
Date of last panoramic x-ray_____ Any previous ortho treatment? Y or N
Previous orthodontist_____ Date of treatment_____

Medical History
Please circle if the patient has or had any of the following:

Heart disease	Epilepsy	Gum disease
Kidney disease	AIDS/HIV+	Current thumb habit
High blood pressure	Clicking jaw joints	Past thumb habit
Hepatitis	Frequent headaches	Speech problems
Rheumatic fever	Difficulty chewing	Breathing problems
Heart murmur	Grinding/clenching teeth	Tonsillectomy
Diabetes	Morning jaw stiffness	Allergies _____
Stroke	Pain in jaw joints	

Please list any other relevant medical conditions:
_____
Please list all medications patient is taking:
_____

I the undersigned have given the above information and certify that it is accurate.
Signature _____ Date _____