**MINOR FORM** 



Date:
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## **PATIENT INFORMATION**

Full Name:		Preferred Name:						
Date of Birth:		Social Security #:	Gender:					
Mailing Address:								
How long at this address:		Email address:						
Main Phone #:	Cell Home Work	Second Phone #:	Cell Hom	e Work				
Patient's Dentist:		Date of Last Visit:						
Patient's School:	Grade:	Sports/Hobbies:						
Parent or Guardian Name(s):								
Whom May We Thank for Referring You:								
RESPONSIBLE PARTY INFORMATION	ON							
Primary Responsible Name:		Relationship to Pa	tient:					
	The state of the s							
How long at this address:	<b>-</b>	il address:						
Main Phone #:	Cell Home Work Second Phone #: Cell Home Work							
Date of Birth:	Social Security #:							
Marital Status:	Spouse's Name:							
Employer:	Occupa	How long:						
Second Responsible Name:		Relationship to Pa	tient:					
Mailing Address:		•						
How long at this address:	Ema	il address:						
Main Phone #:		econd Phone #:	Cell Home	e Work				
Date of Birth:	Social Security #	:						
Marital Status:	Spouse's Name:							
Employer:	Occupa	tion:	How long:					
DENTAL INSURANCE INFORMATIO	N							
Subscriber's Name		Relationship to	Patient:					
Employer:		Group #:						
ID# or Social Security #:		Date of Birth:						
Second Insurance Company:		Phone Numbe	r:					
Subscriber's Name		Relationship to	Relationship to Patient:					
Employer:		Group #:						
ID# or Social Security #:		Date of Birth:						
EMERGENCY CONTACT								
Phone Number: Cell: Address:		Home:						
AUULESS.								

## **MEDICAL HISTORY**

Does Your Child Have A Current Medical Problem? YES NO	Name of Physician		Pho	one#_	Date of Last Exam					
Has Your Child Ever Had Any of the Following?  Heart Attack/Stroke YES NO Psychiatric/Learning Problems YES NO Pight/Low Blood Pressure YES NO Epilepsy/Seizures/Fainting Spells YES NO Diabetes YES NO Heart Murur/Heart Disease YES NO Diabetes YES NO Heart Murur/Heart Disease YES NO Diabetes YES NO Heart Murur/Heart Disease YES NO Diabetes YES NO Hervilla Murur/Heart Disease YES NO Diabetes YES NO Hervilla Murur/Heart Disease YES NO Diabetes YES NO Mitral Valve Prolapse YES NO Cancer/Chemotherapy/Radiation YES NO Mitral Valve Prolapse YES NO Asthma YES NO Mitral Valve Prolapse YES NO Asthma YES NO Hepatitis YES NO Diabetes YES NO ADHD YES NO Major Operations YES NO Pain/Pressure/Tightness in Chest YES NO Major Operations YES NO Pain/Pressure/Tightness in Chest YES NO Diabetes YES NO Using Dilatin or Equivalent YES NO Using Anxiety Medical Conditions  Please Check All That Apply  Pregnant YES NO Premature Birth YES NO Using Hormones (inc. Birth Control) YES NO Using Anxiety Medicalions YES NO Genetic Disorder YES NO List Any Other Medical Conditions  Please Check All Taking Medications YES NO Blood (Liver, Iron, Pillis) YES NO No Norves (Trianquilizers/Relixants) YES NO Blood (Liver, Iron, Pillis) YES NO Norves (Trianquilizers/Relixants) YES NO Allergies YES NO Allergies YES NO Headaches YES NO Norves (Trianquilizers/Relixants) YES NO Allergies YES NO Allergies YES NO Allergies YES NO Allergies YES NO Norves (Trianquilizers/Relixants) YES NO Allergies YES NO Norves (Trianquilizers/Relixants) YES NO Headaches YES NO Norves (Trianquilizers/Relixants) YES NO Allergies YES NO Allergies YES NO Norves (Trianquilizers/Relixants) YES NO Allergies YES NO Allergies YES NO Norves (Trianquilizers/Relixants) YES NO Allergies YES NO Control Alle										
Heart Attack/Stroke	Does Your Child Have A Current Medical F	Problem?	YES	NO	If YES, What?					
High/Low Blood Pressure   YES   NO   Epilepsy/Setzures/Fainting Spells   YES   NO   Diabetes   YES   NO   Heart Murmur/Heart Disease   YES   NO   NO   NO   NO   NO   NO   NO   N	Has Your Child Ever Had Any of the Following?									
Diabetes         YES         NO         Heart Murmur/Heart Disease         YES         NO           Rheumatic Fever         YES         NO         HIV-/Alds         YES         NO           Hemophilia/Abnomal Bleeding         YES         NO         Heart Surgery/Pacemaker         YES         NO           Cancer/Chemotherapy/Radiation         YES         NO         Mitral Valve Prolapse         YES         NO           Kidney Problems         YES         NO         Artificial Bones/Joints         YES         NO           Ashma         YES         NO         Sinus/Breathing Problems         YES         NO           Adenoids/Tonsils Removed         YES         NO         Hepatitis         YES         NO           Adenoids/Tonsils Removed         YES         NO         Hepatitis         YES         NO           Adenoids/Tonsils Removed         YES         NO         Congenital Heart Disease         YES         NO           Adenoids/Tonsils Removed         YES         NO         PolaniPressure/Tightness in Chest         YES         NO           USing/Philis, Gonorrhea         YES         NO         Pain/Pressure/Tightness in Chest         YES         NO           List Any Other Medical Conditions         YES	Heart Attack/Stroke	YES	NO		Psychiatric/Learning Problems	YES	NO			
Rheumatic Fever         YES         NO         HIV+/Aids         YES         NO           Hemophilia/Abnormal Bleeding         YES         NO         Heart Surgery/Pacemaker         YES         NO           Cancer/Chemotherapy/Radiation         YES         NO         Mitral Valve Prolapse         YES         NO           Kidney Problems         YES         NO         Artificial Bones/Joints         YES         NO           Ashma         YES         NO         Sinus/Breathing Problems         YES         NO           Adenoids/Tonsils Removed         YES         NO         Hepatitis         YES         NO           Adenoids/Tonsils Removed         YES         NO         Congenital Heart Disease         YES         NO           Adenoids/Tonsils Removed         YES         NO         ADHD         YES         NO           VID (Syphilis, Gonorrhea)         YES         NO         ADHD         YES         NO           VID (Syphilis, Gonorrhea)         YES         NO         ADHD         YES         NO           Major Operations         YES         NO         Permature Birth         YES         NO           Please Check All That Apply         YES         NO         Using Dilatin or Equivalent	High/Low Blood Pressure	YES	NO		Epilepsy/Seizures/Fainting Spells	YES	NO			
Hemophilia/Abnormal Bleeding	Diabetes	YES	NO		Heart Murmur/Heart Disease	YES	NO			
Cancer/Chemotherapy/Radiation YES NO Mitral Valve Prolapse YES NO Kidney Problems YES NO Artificial Bones/Joints YES NO Artificial Bones/Joints YES NO Asthma YES NO Sinus/Breathing Problems YES NO Adenoids/Tonsils Removed YES NO Hepatitis YES NO Tuberculosis YES NO Congenital Heart Disease YES NO Tuberculosis YES NO ADHD YES NO ADHD YES NO ADHD YES NO Pain/Pressure/Tightness in Chest YES NO Major Operations YES NO Pain/Pressure/Tightness in Chest YES NO List Any Other Medical Conditions  **Please Check All That Apply**  **Pregnant YES NO Premature Birth YES NO Using Dilatin or Equivalent YES NO Using Hormones (inc. Birth Control) YES NO Using Anxiety Medications YES NO Birth Control YES NO List Any Other Medical Conditions  **Pas NO Birth Control YES NO Birth Control YES NO List Any Other Medical Conditions**  **Is Your Child Taking Medications**  **Is Your Child Taking Medications**  **JES NO Blood (Liver, Iron, Pills) YES NO Slomach Trouble YES NO Headraches YES NO Allergies YES NO Theat/Plood Pressure YES NO Allergies YES NO Allergies YES NO Allergies YES NO YES NO Allergies	Rheumatic Fever	YES	NO		HIV+/Aids	YES	NO			
Kidney Problems         YES         NO         Artificial Bones/Joints         YES         NO           Asthma         YES         NO         Sinus/Breathing Problems         YES         NO           Adenoids/Tonsils Removed         YES         NO         Hepatitis         YES         NO           Tuberculosis         YES         NO         Congenital Heart Disease         YES         NO           VD (Syphilis, Gonorrhea)         YES         NO         ADHD         YES         NO           Major Operations         YES         NO         Pain/Pressure/Tightness in Chest         YES         NO           List Any Other Medical Conditions         YES         NO         Premature Birth         YES         NO           Please Check All That Apply         YES         NO         Using Dilatin or Equivalent         YES         NO           On A Prescribed Diet         YES         NO         Using Hormones (inc. Birth Control)         YES         NO           Using Anxiety Medications         YES         NO         Birth Control         YES         NO           Have you taken Bisphosphonate Drugs?         YES         NO         Genetic Disorder         YES         NO           List Any Other Medical Conditions         YES </td <td>Hemophilia/Abnormal Bleeding</td> <td>YES</td> <td>NO</td> <td></td> <td>Heart Surgery/Pacemaker</td> <td>YES</td> <td>NO</td>	Hemophilia/Abnormal Bleeding	YES	NO		Heart Surgery/Pacemaker	YES	NO			
Ashtma YES NO Sinus/Breathing Problems YES NO Adenoids/Tonsils Removed YES NO Hepatitis YES NO Tuberculosis YES NO Congenital Heart Disease YES NO VO (Syphilis, Gonorrhea) YES NO ADHO YES NO ADHO YES NO Major Operations YES NO Pain/Pressure/Tightness in Chest YES NO Major Operations YES NO Pain/Pressure/Tightness in Chest YES NO Major Operations YES NO Pain/Pressure/Tightness in Chest YES NO Major Operations YES NO Premature Birth YES NO On A Prescribed Diet YES NO Using Dilatin or Equivalent YES NO Using Dilatin or Equivalent YES NO Using Arxiety Medications YES NO Using Hormones (Inc. Birth Control) YES NO Using Arxiety Medications YES NO Birth Control YES NO Using Arxiety Medical Conditions  Is Your Child Taking Medications For:  Diabetes YES NO Blood (Liver, Iron, Pills) YES NO Nerves (Tranquilizers/Relaxants) YES NO Stomach Trouble YES NO Sleeping YES NO Allergies YES NO A	Cancer/Chemotherapy/Radiation	YES	NO		Mitral Valve Prolapse	YES	NO			
Adenoids/Tonsils Removed         YES         NO         Hepatitis         YES         NO           Tuberculosis         YES         NO         Congenital Heart Disease         YES         NO           VD (Syphilis, Gonorrhea)         YES         NO         ADHD         YES         NO           Major Operations         YES         NO         Pain/Pressure/Tightness in Chest         YES         NO           List Any Other Medical Conditions         VES         NO         Premature Birth         YES         NO           Pregnant         YES         NO         Using Dilatin or Equivalent         YES         NO           On A Prescribed Diet         YES         NO         Using Hormones (Inc. Birth Control)         YES         NO           Using Anxiety Medications         YES         NO         Birth Control         YES         NO           Have you taken Bisphosphonate Drugs?         YES         NO         Genetic Disorder         YES         NO           List Any Other Medical Conditions         FUS         NO         Blood (Liver, Iron, Pills)         YES         NO           Nerves (Tranquillizers/Relaxants)         YES         NO         Stomach Trouble         YES         NO           Sleeping         YES	Kidney Problems	YES	NO		Artificial Bones/Joints	YES	NO			
Tuberculosis YES NO Congenital Heart Disease YES NO VD (Syphilis, Gonorrhea) YES NO ADHD YES NO ADHD YES NO Major Operations YES NO Pain/Pressure/Tightness in Chest YES NO Pain/Pressure/Tightness in Chest YES NO List Any Other Medical Conditions  Please Check All That Apply  Pregnant YES NO Premature Birth YES NO On A Prescribed Diet YES NO Using Dilatin or Equivalent YES NO Using Thyroid Drugs YES NO Using Hormones (Inc. Birth Control) YES NO Using Anxiety Medications YES NO Birth Control YES NO Enetic Disorder YES NO Enetic Disorder YES NO List Any Other Medical Conditions  Is Your Child Taking Medications For:  Diabetes YES NO Blood (Liver, Iron, Pills) YES NO Sleeping YES NO Headaches YES NO Headaches YES NO Allergies YES NO DENIA PRES NO Allergies YES NO Allergies YES NO Allergies YES NO CONTROL	Asthma	YES	NO		Sinus/Breathing Problems	YES	NO			
VPC (Syphilis, Gonorrhea) VPS NO ADHD VPS NO Major Operations VPS NO Pain/Pressure/Tightness in Chest VPS NO List Any Other Medical Conditions  Please Check All That Apply  Pregnant VPS NO On A Prescribed Diet VPS NO Using Dilatin or Equivalent VPS NO Using Hormones (Inc. Birth Control) VPS NO Using Anxiety Medications VPS NO Have you taken Bisphosphonate Drugs? VPS NO Clatt Any Other Medical Conditions  Is Your Child Taking Medications VPS NO Blood (Liver, Iron, Pills) VPS NO Sleeping VPS NO Blood (Liver, Iron, Pills) VPS NO Sleeping VPS NO Headaches VPS NO Allergies VPS NO Clatex/Rubber Globes VPS	Adenoids/Tonsils Removed	YES	NO		Hepatitis	YES	NO			
Major Operations YES NO Pain/Pressure/Tightness in Chest YES NO List Any Other Medical Conditions  Please Check All That Apply  Pregnant YES NO Premature Birth YES NO On A Prescribed Diet YES NO Using Dilatin or Equivalent YES NO Using Thyroid Drugs YES NO Using Hormones (Inc. Birth Control) YES NO Using Anxiety Medications YES NO Birth Control YES NO Have you taken Bisphosphonate Drugs? YES NO Genetic Disorder YES NO List Any Other Medical Conditions  Is Your Child Taking Medications For:  Diabetes YES NO Blood (Liver, Iron, Pills) YES NO Nerves (Tranquilizers/Relaxants) YES NO Stomach Trouble YES NO Nerves (Tranquilizers/Relaxants) YES NO Headaches YES NO Heart/Blood Pressure YES NO Allergies  Aspirin/Codeine YES NO Penicillin/Tetracycline/Erythromycin YES NO Sulfa Drugs YES NO Other Antibiotics YES NO Dental Anesthetic (Ex. Novocain) YES NO Latex/Rubber Globes YES NO	Tuberculosis	YES	NO		Congenital Heart Disease	YES	NO			
Please Check All That Apply  Pregnant YES NO Premature Birth YES NO On A Prescribed Diet YES NO Using Dilatin or Equivalent YES NO Using Thyroid Drugs YES NO Using Hormones (Inc. Birth Control) YES NO Using Anxiety Medications YES NO Birth Control YES NO Have you taken Bisphosphonate Drugs? YES NO Genetic Disorder YES NO Itist Any Other Medical Conditions  Is Your Child Taking Medications For:  Diabetes YES NO Blood (Liver, Iron, Pills) YES NO Nerves (Tranquilizers/Relaxants) YES NO Stomach Trouble YES NO Allergies YES NO DIALIPATION YES NO DIALIPATION YES NO NO SUM Allergies YES NO Allergies YES NO Penicillin/Tetracycline/Erythromycin YES NO Sulfa Drugs YES NO Other Antibiotics YES NO DIALIPATION YES	VD (Syphilis, Gonorrhea)	YES	NO		ADHD	YES	NO			
Please Check All That Apply  Pregnant YES NO Premature Birth YES NO On A Prescribed Diet YES NO Using Dilatin or Equivalent YES NO Using Thyroid Drugs YES NO Using Hormones (Inc. Birth Control) YES NO Using Anxiety Medications YES NO Birth Control YES NO Have you taken Bisphosphonate Drugs? YES NO Genetic Disorder YES NO List Any Other Medical Conditions  Is Your Child Taking Medications For:  Diabetes YES NO Blood (Liver, Iron, Pills) YES NO Nerves (Tranquilizers/Relaxants) YES NO Stomach Trouble YES NO Sleeping YES NO Headraches YES NO Allergies YES NO DIATE Of the Are You Aware of Any Allergies:  Aspirin/Codeine YES NO Penicillin/Tetracycline/Erythromycin YES NO Sulfa Drugs YES NO Chatex/Rubber Globes YES NO Latex/Rubber Globes YES NO YES NO Latex/Rubber Globes	Major Operations	YES	NO		Pain/Pressure/Tightness in Chest	YES	NO			
Pregnant YES NO Premature Birth YES NO On A Prescribed Diet YES NO Using Dilatin or Equivalent YES NO Using Thyroid Drugs YES NO Using Hormones (Inc. Birth Control) YES NO Using Anxiety Medications YES NO Birth Control YES NO Birth Control YES NO Have you taken Bisphosphonate Drugs? YES NO Genetic Disorder YES NO List Any Other Medical Conditions  Is Your Child Taking Medications For:  Diabetes YES NO Blood (Liver, Iron, Pills) YES NO No Nerves (Tranquilizers/Relaxants) YES NO Stomach Trouble YES NO Sleeping YES NO Headaches YES NO Allergies YES NO Latex/Rubber Globes YES NO Child Drugs YES NO Child Drugs YES NO Chatex/Rubber Globes YES NO Chatex/Rubber Globes YES NO Chatex/Rubber Globes YES NO Chatex/Rubber Globes	List Any Other Medical Conditions									
On A Prescribed Diet YES NO Using Dilatin or Equivalent YES NO Using Thyroid Drugs YES NO Using Hormones (Inc. Birth Control) YES NO Using Anxiety Medications YES NO Birth Control YES NO Have you taken Bisphosphonate Drugs? YES NO Genetic Disorder YES NO List Any Other Medical Conditions  Is Your Child Taking Medications For:  Diabetes YES NO Blood (Liver, Iron, Pills) YES NO Nerves (Tranquilizers/Relaxants) YES NO Stomach Trouble YES NO Sleeping YES NO Headaches YES NO Allergies YES NO Allergies YES NO Allergies YES NO Surfact YES NO Are You Aware of Any Allergies:  Aspirin/Codeine YES NO Penicillin/Tetracycline/Erythromycin YES NO Sulfa Drugs YES NO Cher Antibiotics Y	Please Check All That Apply									
Using Thyroid Drugs YES NO Using Hormones (Inc. Birth Control) YES NO Using Anxiety Medications YES NO Birth Control YES NO Have you taken Bisphosphonate Drugs? YES NO Genetic Disorder YES NO List Any Other Medical Conditions  Is Your Child Taking Medications For:  Diabetes YES NO Blood (Liver, Iron, Pills) YES NO Nerves (Tranquilizers/Relaxants) YES NO Stomach Trouble YES NO Sleeping YES NO Headaches YES NO Heart/Blood Pressure YES NO Allergies YES NO  Are You Aware of Any Allergies:  Aspirin/Codeine YES NO Penicillin/Tetracycline/Erythromycin YES NO Sulfa Drugs YES NO Other Antibiotics YES NO Dental Anesthetic (Ex. Novocain) YES NO Latex/Rubber Globes YES NO	Pregnant	YES	NO		Premature Birth	YES	NO			
Using Anxiety Medications YES NO Birth Control YES NO Have you taken Bisphosphonate Drugs? YES NO Genetic Disorder YES NO List Any Other Medical Conditions  Is Your Child Taking Medications For:  Diabetes YES NO Blood (Liver, Iron, Pills) YES NO Nerves (Tranquilizers/Relaxants) YES NO Stomach Trouble YES NO Sleeping YES NO Headaches YES NO Heart/Blood Pressure YES NO Allergies YES NO  Are You Aware of Any Allergies:  Aspirin/Codeine YES NO Penicillin/Tetracycline/Erythromycin YES NO Sulfa Drugs YES NO Other Antibiotics YES NO Dental Anesthetic (Ex. Novocain) YES NO Latex/Rubber Globes	On A Prescribed Diet	YES	NO		Using Dilatin or Equivalent	YES	NO			
Have you taken Bisphosphonate Drugs? YES NO Genetic Disorder YES NO  List Any Other Medical Conditions  Is Your Child Taking Medications For:  Diabetes YES NO Blood (Liver, Iron, Pills) YES NO  Nerves (Tranquilizers/Relaxants) YES NO Stomach Trouble YES NO  Sleeping YES NO Headaches YES NO  Heart/Blood Pressure YES NO Allergies YES NO  Are You Aware of Any Allergies:  Aspirin/Codeine YES NO Penicillin/Tetracycline/Erythromycin YES NO  Sulfa Drugs YES NO Other Antibiotics YES NO  Dental Anesthetic (Ex. Novocain) YES NO Latex/Rubber Globes YES NO	Using Thyroid Drugs	YES	NO		Using Hormones (Inc. Birth Control)	YES	NO			
List Any Other Medical Conditions  Is Your Child Taking Medications For:  Diabetes YES NO Blood (Liver, Iron, Pills) YES NO Nerves (Tranquilizers/Relaxants) YES NO Stomach Trouble YES NO Sleeping YES NO Headaches YES NO Headaches YES NO Allergies YES NO Allergies YES NO Stomach Trouble YES NO Dental Anesthetic (Ex. Novocain) YES NO Latex/Rubber Globes YES NO NO Dental Anesthetic (Ex. Novocain)	Using Anxiety Medications	YES	NO		Birth Control	YES	NO			
Diabetes YES NO Blood (Liver, Iron, Pills) YES NO Nerves (Tranquilizers/Relaxants) YES NO Stomach Trouble YES NO Sleeping YES NO Headaches YES NO Heart/Blood Pressure YES NO Allergies YES NO  Are You Aware of Any Allergies:  Aspirin/Codeine YES NO Penicillin/Tetracycline/Erythromycin YES NO Sulfa Drugs YES NO Other Antibiotics YES NO Dental Anesthetic (Ex. Novocain) YES NO Latex/Rubber Globes	Have you taken Bisphosphonate Drugs?	YES	NO		Genetic Disorder	YES	NO			
Diabetes YES NO Blood (Liver, Iron, Pills) YES NO Nerves (Tranquilizers/Relaxants) YES NO Stomach Trouble YES NO Sleeping YES NO Headaches YES NO Headaches YES NO Allergies YES NO Allergies YES NO Sleeping YES NO ON Allergies YES NO DEntal Anesthetic (Ex. Novocain) YES NO Latex/Rubber Globes YES NO Latex/Rubber Globes	List Any Other Medical Conditions									
Nerves (Tranquilizers/Relaxants)       YES       NO       Stomach Trouble       YES       NO         Sleeping       YES       NO       Headaches       YES       NO         Heart/Blood Pressure       YES       NO       Allergies       YES       NO         Are You Aware of Any Allergies:       XES       NO       Penicillin/Tetracycline/Erythromycin       YES       NO         Sulfa Drugs       YES       NO       Other Antibiotics       YES       NO         Dental Anesthetic (Ex. Novocain)       YES       NO       Latex/Rubber Globes       YES       NO	Is Your Child Taking Medications Fo	or:								
Sleeping YES NO Headaches YES NO Headaches YES NO Allergies YES NO Allergies YES NO Are You Aware of Any Allergies:  Aspirin/Codeine YES NO Penicillin/Tetracycline/Erythromycin YES NO Sulfa Drugs YES NO Other Antibiotics YES NO Dental Anesthetic (Ex. Novocain) YES NO Latex/Rubber Globes YES NO	Diabetes	YES	NO		Blood (Liver, Iron, Pills)	YES	NO			
Heart/Blood Pressure YES NO Allergies YES NO  Are You Aware of Any Allergies:  Aspirin/Codeine YES NO Penicillin/Tetracycline/Erythromycin YES NO Sulfa Drugs YES NO Other Antibiotics YES NO Dental Anesthetic (Ex. Novocain) YES NO Latex/Rubber Globes YES NO	Nerves (Tranquilizers/Relaxants)	YES	NO		Stomach Trouble	YES	NO			
Are You Aware of Any Allergies:  Aspirin/Codeine YES NO Penicillin/Tetracycline/Erythromycin YES NO Sulfa Drugs YES NO Other Antibiotics YES NO Dental Anesthetic (Ex. Novocain) YES NO Latex/Rubber Globes YES NO	Sleeping	YES	NO		Headaches	YES	NO			
Aspirin/Codeine YES NO Penicillin/Tetracycline/Erythromycin YES NO Sulfa Drugs YES NO Other Antibiotics YES NO Dental Anesthetic (Ex. Novocain) YES NO Latex/Rubber Globes YES NO	Heart/Blood Pressure	YES	NO		Allergies	YES	NO			
Sulfa Drugs     YES     NO     Other Antibiotics     YES     NO       Dental Anesthetic (Ex. Novocain)     YES     NO     Latex/Rubber Globes     YES     NO	Are You Aware of Any Allergies:									
Dental Anesthetic (Ex. Novocain)  YES NO  Latex/Rubber Globes  YES NO	Aspirin/Codeine	YES	NO		Penicillin/Tetracycline/Erythromycin	YES	NO			
	Sulfa Drugs	YES	NO		Other Antibiotics	YES	NO			
Metal/Nickel Allergies YES NO Other YES NO	Dental Anesthetic (Ex. Novocain)	YES	NO		Latex/Rubber Globes	YES	NO			
	Metal/Nickel Allergies	YES	NO		Other	YES	NO			

## **DENTAL HISTORY**

What is the main reason for seeking Orthodontic Treatment?							
Has your child had previous Orthodontic Treatment? If so, by whom?							
Does your child have missing permanent teeth?	If so, List_						
Does your child Pre-Medicate before their Dental Appointment?						YES	NO
Do your child's gums bleed when they are brushi	ing?					YES	NO
Has your child ever been told they have 'Gum Di	sease' or l	Periodonti	tis?			YES	NO
Has your child ever had professional instructions	on Denta	I Home Ca	are?			YES	NO
Is any part of your child's mouth sensitive to temp	perature o	r pressure	?			YES	NO
Does food catch between your child's teeth?						YES	NO
Does your child have any soreness around their	eyes or ea	ars?				YES	NO
Does your child have any unpleasant odor, or tas	ste in their	mouth?				YES	NO
Are you or your child dissatisfied with the appearance of their teeth?					YES	NO	
Is your child currently experiencing any pain?						YES	NO
Have other family members had treatment in our	office?					YES	NO
Does Your Child Have Any of the Fo		2					
•		•					
Ringing in the Ears	YES	NO		Pain in Teeth		YES	NO
Neck Pain	YES	NO		Face Pain		YES	NO
Back Pain	YES	NO		Jaw Pain		YES	NO
Headaches	YES	NO		Grinding of Teeth		YES	NO
Dizziness	YES	NO		Popping/Clicking of	f Jaw Joint	YES	NO
Has Your Child Ever Experienced the	e Follov	ving?					
Been in an accident?	YES	NO	Explain				
A blow to the jaw?	YES	NO	Explain_				
An injury to the mouth/teeth/chin?	YES	NO	Explain				
Their jaw joint locked or felt like it was sticking?	YES	NO	Explain_				
Would you say your child's Dental Health is:		POOR		FAIR	GOOD		
By signing below, I certify that the information provided today is complete and accurate. I also understand that it is my responsibility to inform the office of any changes regarding my child's medical health. I authorize Bailey Orthodontics Staff to perform necessary dental services that my child may need during diagnosis and treatment.							
I hereby authorize my insurance benefits to be paid directly to Bailey Orthodontics Office and I authorize Bailey Orthodontics to release any information to process insurance claims.							
Signature				Da	te		