Dr. Neeraj Pershad
Orthodontist

NIAGARA PENINSULA orthodontics

Child Patient History Form

Name _____ Age____ Sex____ DOB_____ Grade_____ School_____

Address_____ City_____ Postal Code_____ Tel _____

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

Responsible party, please provide the following information:

Name_____ Email_____ Relationship to Patient_____ _____

Address _____ Home Tel _____ Work Tel_____

Does responsible party have Orthodontic Insurance? ☐ Yes ☐ No Name of Ins company_____

MEDICAL HISTORY: Physician:_____ Phone:_____

Has patient had or does patient have any of the following?

Rheumatic fever ☐Y ☐N	Herpes ☐Y ☐N	Prolonged Bleeding ☐Y ☐N	Asthma ☐Y ☐N
Heart Murmur ☐Y ☐N	Tuberculosis ☐Y ☐N	Epilepsy ☐Y ☐N	Swollen glands ☐Y ☐N
Mitral Valve Prolapse ☐Y ☐N	HIV/ AIDS ☐Y ☐N	Mental health problems ☐Y ☐N	Arthritis ☐Y ☐N
Heart Disease ☐Y ☐N	Hepatitis A, B or C ☐Y ☐N	Diabetes ☐Y ☐N	Allergies ☐Y ☐N
Artificial Heart Valve ☐Y ☐N	STD's ☐Y ☐N	Kidney disease ☐Y ☐N	Other:_____
Artificial Joints ☐Y ☐N	Blood disease ☐Y ☐N	Liver Disease ☐Y ☐N	_____

If you responded YES to any of the above, please give other significant information _____

_____

Is the child under a physician's care at present? If yes, reason_____

Does the child have any history of major illness and/ or operations? _____

Is the child allergic to any medications? (E.g. aspirin, penicillin, etc.) If yes, what? _____

Please list any medications being taken_____

Does the child have tendency to colds? _____ Sore throats? _____ Ear infections? _____

Have the tonsils or adenoids been removed? _____

Has the patient reached puberty? Girls-Has menstruation started? ☐ Yes ☐ No Boys-Has voice changed? ☐ Yes ☐ No

Are there other children in the family? Names and ages_____

Has any other member of the family had orthodontic treatment?_____ At this office? ☐ Yes ☐ No

Please describe why you sought this consultation_____

_____

DENTAL HISTORY: Dentist:_____ Date of last visit:_____

Yes No

- ☐ ☐ Does the child require any dental work including cleanings, extractions or fillings?_____
- ☐ ☐ Have there been any injuries to the child's face, mouth or teeth? If yes, describe_____
- ☐ ☐ Has the child ever fallen and bumped their chin, or received a blow to their jaws? If yes, describe_____
- ☐ ☐ Have you been informed of any missing or extra permanent teeth? If yes, list_____
- ☐ ☐ Has the child ever had any surgery in the head and neck area? If yes, describe_____
- ☐ ☐ Has the child ever sucked his/her thumb/finger? _____ Until what age?_____
- ☐ ☐ Has the child ever had an orthodontic examination? _____ Does the child want treatment?_____

List any sports, hobbies or musical instruments:_____

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

_____ _____

Signature of Parent or Guardian Date

_____ _____ Doctor

NOTES:_____

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