Medical Dental History Form For Children

Child's Name: _____

(Last) (First) (Middle)

Nickname: _____ **Male** _____ **Female** _____ **Birthdate** _____/_____/_____ **Age:** _____

Address: _____

Street City State Zip

Parent bringing child: _____**DOB**_____

(Last) (First) (Middle)

Parent's Address: _____

Street City State Zip

Home Phone: (_____) _____ **Cell:** (_____) _____ **Work:** (_____) _____ **Ext.** _____

Parent's SS#: _____ **Parent's DOB:** _____ **Email Address:** _____

Employer: _____ **How long there?** _____**Occupation:** _____

Employer's Address: _____

Street City State Zip

How did you hear about our office? **Internet** **Insurance Co.** **Dentist**
Friend-Who? _____ **Other** _____

Orthodontic Insurance Information

Dental Coverage: _____**Yes** _____**No** **Dental Insurance Co.:** _____

ID # _____ **Group #** _____ **Phone #** (_____) _____

Insurance Co. Address: _____

Insurance Subscriber's Name: _____**Their Birthdate**_____

Their relation to child: _____ **Their SS#** _____ **Employer** _____

Release and Waiver

I authorize release of any information regarding my orthodontic treatment to my dental insurance company.

Signature _____ **Date** _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in completion of this form. I will notify my orthodontist of any changes in my medical/dental health.

Signature _____ **Date** _____

3019-B North Druid Hills Rd NE Atlanta, GA 30329 Office (404) 417-0771 Fax (404) 417-0772
990-B Whitlock Ave NW Marietta, GA 30064 Office (770) 670-6916 Fax (678) 426-3226
www.drwrightortho.com

Medical History

Circle any of the following medical conditions your child has had or are currently being treated for:

Congenital Heart Defect	**Heart Murmur**	**Herpes**	**Mitral Valve Prolapse**	**Pregnancy**
Epilepsy	**Hepatitis**	**HIV/AIDS**	**Mouth Ulcers**	

List any medical conditions not listed that you feel we should be aware of:

_____
_____
_____

Circle any allergic reactions to the following: **Latex** **Jewelry/Metals** **Vinyl** **Plastics**

Other: _____

Dental History

Dentist Name: _____ **Date of last visit:** _____/_____/_____

What concerns do you have about your child's teeth:

_____
_____

YES NO Does your child have any type of thumb or tongue habit?

YES NO Does your child tend to breathe through their mouth?

YES NO Has your child ever had Orthodontic treatment before?

YES NO Does your child clench or grind their teeth?

YES NO Does your child's jaw click, pop, or hurt? If yes, please explain: _____

Benefits of Orthodontics

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Wright to perform a complete orthodontic evaluation.

Signature: _____ **Date:** _____

Wright
ORTHODONTICS

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