WELCOME TO DR. SANFORD'S OFFICE!

Dear Parent, Please thoroughly complete both pages of this health history form.

Patient's Name: _____ Prefer to be called:_____ Sex:_____

Date of Birth: _____ Age: _____ School: _____

Mother's Full Name: _____ Father's Full Name_____

Names of Parents patient lives with_____

Address: _____

Home Phone _____ Cell _____ Work #_____

Parent's Email _____

Occupation_____ Employer_____

NJ driver license#_____ SS#_____

General Dentist: _____ Address:_____

How did you learn about our office? Please circle one or more: Internet search, school talks, direct mailing, sibling, friends, Invisalign search, yellow pages or dentist.

Do you have a: Latex allergy? □Yes □No

Heart murmur? □Yes □No If YES, do you require Pre-Medication? □Yes □No

If YES, which physician monitors this health issue?

Name & address: _____

Who noticed your child's orthodontic issue? □Parent □Dentist □ Speech Teacher □ Other_____

Please describe your child's orthodontic matter in your own words: _____

_____

What are some of your child's interests or hobbies? _____

Siblings' Names and birthdates:_____

Do you employ an au pair? □No □Yes If yes, name & cell _____

All of the following questions refer to YOUR CHILD. Your answers will be helpful in selecting the safest and most effective means of providing your child's orthodontic care.

Please turn over to fill out page 2>>>>

MEDICAL HISTORY

Pediatrician_____**Address**_____**Phone**_____

Has patient experienced any health problems? ☐No ☐Yes

If yes, please explain _____

Any major change in patient's health recently? ☐No ☐Yes

If yes, please explain _____

Is patient currently under physician's care? ☐No ☐Yes

If yes, please explain _____

Is patient currently taking medications? ☐No ☐Yes

If yes, please list _____

Is patient allergic to any medications? ☐No ☐Yes List _____

Has patient received a blood transfusion? ☐No ☐Yes Reason_____

Have tonsils or adenoids been removed? ☐No ☐Yes When_____

Has patient been in a risk group for AIDS? ☐No ☐Yes Explain_____

Has your child had any of the following conditions?:

Heart Surgery…… ☐No ☐Yes Hepatitis…… ☐No ☐Yes Emotional Difficulties… ☐No ☐Yes Anemia … ☐No ☐Yes
Rheumatic Fever….. ☐No ☐Yes Diabetes…… ☐No ☐Yes Frequent Headaches……☐No ☐Yes Bronchitis…☐No ☐Yes
Endocrine Disorders ☐No ☐Yes Kidney Disease…….☐No ☐Yes Nervous/Anxious…….. ☐No ☐Yes Tonsillitis….☐No ☐Yes
Prolonged Bleeding… ☐No ☐Yes Liver Disease…. ☐No ☐Yes Cancer…… ☐No ☐Yes Asthma…... ☐No ☐Yes
Bone Disorders…… ☐No ☐Yes Tuberculosis……. ☐No ☐Yes Hives/Rash…… ☐No ☐Yes Epilepsy… ☐No ☐Yes
Growth Disorders…… ☐No ☐Yes Mouth Breather… ☐No ☐Yes, When? Awake _____ Asleep _____
Development Disorder…☐No ☐Yes Herpes Simplex/Fever Blisters …….☐No ☐Yes Fainting ……☐No ☐Yes

Is there any other condition or problem that you think we should know about? _____

_____

GROWTH INFORMATION FOR PATIENTS UNDER 16 YEARS OF AGE- Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are needed to aid in our selection of treatment alternatives.

Has your son or daughter reached puberty? ☐No ☐Yes Girls – Has she started menstruation? ☐ No ☐Yes When?_____

Boys - Has his voice changed? ☐ No ☐Yes When?_____

Child's Height _____ **Do you think growth is completed? ☐No ☐Yes**
Father's Height _____ **Mother's Height** _____

Is your child adopted? ☐ No ☐Yes

Have either siblings or parents had orthodontic treatment? ☐ No ☐Yes, with Dr._____

DENTAL HISTORY

Frequency of dental checkups: ☐Twice a Year ☐Once a Year ☐Only if a problem occurs ☐Never Date of last visit_____

Is there any unfinished care to be completed by patient's dentist? ☐No ☐Yes Explain_____

Is patient frightened about dental treatment? ☐No ☐Yes Explain_____

Any previous unpleasant dental experiences? ☐No ☐Yes Explain_____

Has patient had any face or dental injuries? ☐No ☐Yes Explain _____

Is there a history of thumb or finger sucking? ☐No ☐Yes If yes, Stopped? ☐No ☐Yes When?_____

Does patient play any musical instruments? ☐No ☐Yes What instrument?_____

Has patient consulted another orthodontist or had previous ortho treatment? ☐No ☐Yes, with whom?_____

Have teeth (either primary or permanent) been removed? ☐No ☐Yes Explain_____

Please check if there is a history of:

☐ Clenching teeth ☐ Muscular Soreness around head & neck ☐ Jaw joint soreness ☐ Jaw joint popping ☐ Jaw joint clicking
☐ Grinding teeth ☐ Headaches (more than normal) ☐ Ringing in the ears ☐Speech Problems w/sounds:_____

Is there any other information that may be helpful?_____

Parents signature _____ **Date**_____ **Reviewed by**_____