

Dr. Brian Hurd *Orthodontist*

CHILD HEALTH HISTORY FORM

PATIENTS NAME _____

SEX _____ BIRTHDATE _____ AGE _____ GRADE _____ SCHOOL _____

ADDRESS _____ HOME PHONE _____

FATHER'S ADDRESS _____ FATHERS WORK PHONE _____ FATHERS EMPLOYER _____

MOTHER'S ADDRESS _____ MOTHERS WORK PHONE _____ MOTHERS EMPLOYER _____

FATHER'S ADDRESS: AS ABOVE? Y N MOTHER'S ADDRESS: AS ABOVE? Y N IF DIFFERENT, PLEASE SPECIFY _____

SIBLINGS: NAMES AND AGES _____

Have we treated any other family member? Y N If so, please list names: _____

Do you have general dental insurance? Y N Do you have orthodontic insurance? Y N

Patient's dentist: _____ Patient's Physician _____

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

Please list any favourite sports or hobbies: _____

Person Financially Responsible: Mother Father Both Parents

What is your reason for arranging an orthodontic consultation? _____

Has any family member a similar bite or jaw problem? Y N

Has the patient previously worn any orthodontic appliance such as retainers, braces, spacers etc. Y N

Has the patient sucked thumb or finger? Y N

Have tonsils or adenoids been removed? Y N

Difficulty breathing through nose? Y N Unusual number of headaches? Y N

Do your jaws click, crack or lock upon opening? Y N

Do you grind or clench your teeth? Y N

Do you have any of the following? (Please circle yes or no)

Asthma	Yes	No
Hayfever	Yes	No
Bleeding Disorder	Yes	No
Hepatitis	Yes	No
Mononucleosis	Yes	No
Rheumatic Fever	Yes	No
Epilepsy	Yes	No
Diabetes	Yes	No
Kidney Disease	Yes	No
Liver Disease	Yes	No
Heart Problems	Yes	No
Latex Allergy	Yes	No
HIV	Yes	No

Is the patient under a physician's care? Y N

Is the patient taking any medication? Y N

Does the patient have any allergies or drug reactions? Y N If so, please describe:

Any additional comments?

Our privacy protocols comply with privacy legislation, standards of our regulatory body, the Royal College of Dental Surgeons of Ontario and the law. Only necessary information is collected and we only share information with your consent.

I hereby consent that Dr. Hurd or his designated staff may release any information pertaining to orthodontic treatment to my dentist or related health professional:

Date _____

Parent/Guardian Signature: _____