

Child/adolescent form

Referred By _____ Date _____
 Patient's Name _____ Preferred Name _____
 Birthdate _____ Age _____ Sex _____ School _____ Grade _____
 Patient's Dentist _____ Physician _____
 Mother's Name _____ SSN _____ Date of Birth _____
 Home Address _____ Home Phone _____
 City/State/Zip _____ Work Phone _____ Cell _____
 Occupation _____ Employed By _____
 Father's Name _____ SSN _____ Date of Birth _____
 Home Address _____ Home Phone _____
 City/State/Zip _____ Work Phone _____ Cell _____
 Occupation _____ Employed By _____
 Primary Dental Insurance _____ Phone _____
 Insured Name _____ Relationship _____
 Name of any family members we have seen _____
 Names and Ages of Other Children in the family _____
 Person(s) responsible for Payment of Account _____
 Address and Relationship to Patient _____

MEDICAL HISTORY

Is the patient in good health? _____ Does the patient have any history of major illness? _____
Please list (give dates) _____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

HEART TROUBLE	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	ATTENTION DEFICIT	<input type="checkbox"/>	LIVER INVOLVMENT	<input type="checkbox"/>
MITRAL VALVE PRO	<input type="checkbox"/>	ANEMIA	<input type="checkbox"/>	KIDNEY PROBLEMS	<input type="checkbox"/>	HEPATITIS	<input type="checkbox"/>
HEART MURMUR	<input type="checkbox"/>	EPILEPSY	<input type="checkbox"/>	ENDOCRINE PROBLEMS	<input type="checkbox"/>	BLOOD DISORDERS	<input type="checkbox"/>
RHEUMATIC FEVER	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	PROLONGED BLEEDING	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>
PNEUMONIA	<input type="checkbox"/>	FAINTING OR DIZZYNESS	<input type="checkbox"/>	TUBERCULOSIS	<input type="checkbox"/>	OTHER _____	<input type="checkbox"/>

Does patient have tendency to: Colds _____ Sore Throats _____ Ear Infections _____ Cold Sores _____
Have tonsils and adenoids been removed? _____ What Age? _____ List any drugs or medications now being taken and reason. _____

LIST ANY ALLERGIES OR DRUG SENSITIVITY _____

Has the patient reached puberty: Girls-has she started menstruation _____ If so date of onset _____
Boys-has his voice changed _____

DENTAL HISTORY

Date of last dental cleaning _____ Date of last X-rays _____
 Has the patient had a Panoramic/Panorex X-ray? **Y / N / Don't know** If yes, When? _____
 Have there been injuries to the face, mouth or teeth? **Y / N** If yes, describe and give date _____
 _____ Has the patient ever sucked a thumb or fingers? **Y/N** Age _____
 Any pain in or near the ears? **Y / N** Does the patient have any speech problems? **Y / N**
 Have you been informed of any missing or extra permanent teeth? **Y/N**
 Has an orthodontist been consulted previously? **Y / N** Has either parent had orthodontic treatment? **Y / N**
 List any musical instruments played _____
 Interests or hobbies _____

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

Signature (parent or guardian's) _____ Reviewed By: _____

OFFICE USE

Date _____

Chief complaint _____

Habits: _____

Trauma _____

TMJ EXAMINATION: Does patient have or report any TMD Symptoms: Y / N

TMD History Required: Y / N

Comments: _____

Extra oral exam

Profile: convex-straight-concave

Midface def: none-mild-moderate-severe

LFH: long-average-short

Chin: weak-avg-strong

Naso-labial angle: acute-avg-obtuse

Mento-Labial sulcus: deep-avg-shallow

Incisor Pro: retrusive-avg-protrusive

Lip incomp: none-mild-moderate-severe

Lip Vermillion: thin-avg-thick

Frontal: Square-Ovoid-Round-Tapering

Symmetry:

Incisor at rest:

Incisor @ smile:

Gingiva @ smile:

Negative Space: none-mild-mod-severe

Smile Tooth Contour: reverse-flat-avg

Intra oral exam

Frenum: high-avg-low

Diastema:

Hygiene: 1 2 3 4 5 (5 best)

Attached Gingiva:

Pathology:



Notes: _____

			E	D	C	B	A	A	B	C	D	E			
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
			E	D	C	B	A	A	B	C	D	E			

- N-ANKYLOSED
- C-CARIES
- X-EXTRACTED
- S-SUPERNUM.
- O-CONG. MISSING
- A-ABNORM SHAPE
- I-IMPACTION
- D-DECID.
- P-CHIPPED
- M-MOBILITY
- W-DECALCIFICATION
- R-ROOT CANAL TX

	PSR
1	
2	
3	
4	
5	
6	

Crowding/Spacing Maxilla _____ mm Mandible _____ mm CR/CO _____ mm direction _____

Angle class: RM _____ RC _____ LM _____ LC _____ OJ= _____ mm OB= _____ mm Crossbites _____

Comments: _____

RECOMMENDATION

RADIOGRAPHS NEEDED: Pano _____ Lateral Ceph _____ PA Ceph _____ Periapical _____ Other _____

Interceptive Tx _____ Limited Tx _____

Full Tx _____ Habit Tx _____

Consults Needed _____ Extractions _____

Tx time _____ Orthognathic Surgery _____

Fee Range _____ Stage: One Two Three

Disposition: Recall _____ (months) Records _____ Will call _____ No tx _____

_____ N¹V: _____

_____ N²V: _____

_____ N³V: _____

_____ N⁴V: _____

_____ N⁵V: _____