Chatham Orthodontics
DR. TERILYN MCHUGH
ORTHODONTIST

CHILD / ADOLESCENT ORTHODONTIC INFORMATION

Patient Information

Patient's Name: First/ Middle/Last

Patient prefers to be called Patient's birth date: Month/Day/Year Patient Sex: Male ❑ Female ❑

Person accompanying the Patient for this appointment: _____

Patient's Address: Street/ City/ Province/ Postal Code

Home Phone Work Phone Cellular Phone

Family Email Address: _____

How would you prefer to be contacted? Home Phone☐ Work Phone☐ Cellular Phone☐ Email☐

Patient's School Grade

Whom may we thank for referring you to our office?

Parent/Guardian Information

Mother: First/ Middle/ Last Occupation

Place of Employment and Address Employment Telephone Number

Mother's Address (if different from the Patient's): Street/ City/ Province/ Postal Code

Father: First/ Middle /Last Occupation

Place of Employment and Address Employment Telephone Number

Father's Address (if different from the Patient's): Street/ City/ Province/ Postal Code

Who is legally responsible for the patient? _____
Parents are: ☐ Married ☐ Divorced ☐ Single ☐ Common Law

Other family members who have been our patients: _____

Medical History

Is your child being treated for any medical condition at present or has he/she been treated within the past year?
Yes ☐ No ☐ If yes please explain: _____

When was his/her last medical checkup? _____

Has there been any change in his/her general health in the past year? Yes ☐ No ☐
If yes please explain: _____

Is your child taking any medications, non-prescription drugs or herbal supplements of any kind? Yes ☐ No ☐
If yes, please explain: _____

Does your child have any allergies to medications, latex/rubber products or other items? Yes ☐ No ☐
If yes please explain: _____

Does your child require antibiotic pre-medication prior to dental work/cleanings? Yes ☐ No ☐

Has your child ever had a peculiar or adverse reaction to any medicine or product? Yes ☐ No ☐
If yes, please explain: _____

Does your child have asthma? Yes ☐ No ☐

Does your child have or has he/she ever had any heart or blood pressure problems? Yes ☐ No ☐

Does your child have or has he/she ever had an artificial heart valve, an infection of the heart (ie: infective endocarditis), or a heart condition from birth (ie: congenital heart disease) or a heart transplant? Yes ☐ No ☐

Does your child have a prosthetic or artificial joint? Yes ☐ No ☐

Does your child have any conditions or therapies that could affect his/her immune system? (ie: leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?) Yes ☐ No ☐

Has your child ever had hepatitis, jaundice or liver disease? Yes ☐ No ☐

Does your child have a bleeding problem or bleeding disorder? Yes ☐ No ☐

Has your child ever had any of the following diseases/medical conditions? Please check off if yes:

Endocrine problems ☐	Rheumatic fever ☐	Pneumonia ☐	Growth hormones ☐	Seizures (epilepsy) ☐
Fainting ☐	Mitral valve prolapse ☐	Lung disease ☐	Diabetes ☐	Kidney disease ☐
Anemia ☐	Heart murmur ☐	Blood transfusion ☐	Cancer ☐	Tuberculosis ☐
Stomach ulcers ☐	Arthritis ☐	Thyroid disease ☐	Drug/alcohol dependency ☐	Depression ☐
Osteoporosis medications (e.g. Fosamax, Actonel) ☐		Pregnancy ☐		

Patient Care Information

_____

Name of Patient's Dentist Name of Family Doctor Telephone number of Family Doctor

Do you attend dental visits regularly: Yes ☐ No ☐ Frequency: Every 6 months ☐ 9 months ☐ 12 months ☐

Does/did your child have any of the following habits?

Clenching/grinding teeth	Yes ☐	No ☐	Nursing bottle habits	Yes ☐	No ☐	Nail biting	Yes ☐	No ☐
Lip sucking/biting	Yes ☐	No ☐	Speech therapy	Yes ☐	No ☐	Mouth breathing	Yes ☐	No ☐
Finger or thumb habit	Yes ☐	No ☐	Is the habit still present	Yes ☐	No ☐	If not present, at what age did it cease: _____		

Have there been any injuries to your child's face, mouth or teeth in the past? Yes ☐ No ☐
If yes, at what age and where? _____

Has your child experienced any jaw joint noises, joint pain or limited jaw movement? Yes ☐ No ☐

Has an orthodontist previously been consulted? Yes ☐ No ☐
If yes, who has been previously consulted and when? _____

Does your child desire orthodontic treatment? Yes ☐ No ☐

What is the main reason that you are visiting our office? _____

_____

If you/your child could change anything about his/her smile, what would it be? _____

_____

Do you know if your child has any missing/extra permanent teeth? Yes ☐ No ☐

Do you have insurance coverage for orthodontic treatment? Yes ☐ No ☐

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status.

Signature _____ Date _____