Whom may we thank for referring you to us? _____

Merrimack Valley Orthodontics

Joseph P. Giordano, DMD - Audra B. Reynoso, DMD

Today's Date: ____/ ___/ _____

Patient Name: (First)_____ (M)_____ (Last)_____ Sex: Male / Female

Nickname: _____DOB: ___ / ___ / _____ Age: _____ Parent's Phone #s (Check Best): ( )_____ ( ) _____

CHILD'S DENTAL HISTORY

Child's Dentist: _____ Phone #: _____ Date of last visit: _____

Why are you interested in orthodontic treatment for your child? _____

_____

Has your child ever been evaluated/had orthodontic treatment before? ☐ Yes ☐ No Have there been any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No

Does your child have any habits/problems affecting the mouth or teeth? ☐ Thumb/finger sucking ☐ Nail biting ☐ Clenching/grinding teeth ☐ Lip sucking/biting ☐ Mouth breather ☐ Tongue thrust Other_____

List any musical instruments played _____

Has anyone in your family received orthodontic treatment? ☐ Yes ☐ No

Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Yes ☐ No

How often does your child brush?_____ Floss? _____

Other information about your child's dental health or previous treatment_____

Has your child's physician recommended pre-medication with antibiotics before dental treatment? ☐ Yes ☐ No

CHILD'S MEDICAL HISTORY

Child's Physician: _____ Phone #: _____Date of last visit: _____

Has your child had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Is your child currently under physician care? ☐ Yes ☐ No If yes, describe _____

Has your child ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

Have your child's adenoids or tonsils been removed? ☐ Yes ☐ No

Check yes or no if your child had any of the following?

☐ Y ☐ N AIDS/HIV Positive	☐ Y ☐ N Diabetes	☐ Y ☐ N Jaw pain	☐ Y ☐ N Shortness of breath
☐ Y ☐ N Anemia	☐ Y ☐ N Epilepsy	☐ Y ☐ N Kidney disease or malfunction	☐ Y ☐ N Sinus problems
☐ Y ☐ N Asthma	☐ Y ☐ N Fainting	☐ Y ☐ N Liver disease	☐ Y ☐ N Skin rash
☐ Y ☐ N Atopic (allergy prone)	☐ Y ☐ N Food allergies	☐ Y ☐ N Material allergies (latex, wool, metal, chemicals)	☐ Y ☐ N Spina Bifida
☐ Y ☐ N Blood disease	☐ Y ☐ N Headaches	☐ Y ☐ N Respiratory disease	☐ Y ☐ N Thyroid disease or malfunction
☐ Y ☐ N Cancer	☐ Y ☐ N Heart problems	☐ Y ☐ N Rheumatic/ Scarlet fever	☐ Y ☐ N Tonsillitis
☐ Y ☐ N Convulsions/Epilepsy	☐ Y ☐ N Hearing impairment		☐ Y ☐ N Tuberculosis
☐ Y ☐ N Cough, persistent	☐ Y ☐ N Hemophilia/Abnormal bleeding		☐ Y ☐ N Other _____
☐ Y ☐ N Cough up blood			

Please describe any Yes answers and discuss any additional medial conditions that your child has had: _____

_____

Please list any medications your child is currently taking: _____

Please list all drugs that your child is allergic to: _____

AUTHORIZATION

I understand that the information that I have given on this questionnaire is accurate to the best of my knowledge. I understand that this information will be held in the strictest confidence and used by the orthodontist to help determine appropriate and healthful orthodontic treatment. It is my responsibility to inform this office of any change in my child's medical status.

_____ _____

Signature of Parent or Guardian Date