

WRIGHT ORTHODONTICS

Has your child ever been evaluated for orthodontic treatment? _____

Doctor's name _____ Date of treatment _____

Has any member of your family ever been treated at our office? _____

Has there been any injuries to the face, mouth, teeth or chin? _____

If so, explain _____

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

Has your child exhibited any of the following habits in the past (mark with X) or still exhibits these habits (mark with 0)?

Thumb Sucking _____ Clenching of teeth _____

Finger Sucking _____ Lip Biting _____

Mouth Breathing _____ Nail Biting _____

Grinding of Teeth _____ Tongue Thrusting _____

Is your child presently in a rapid growth time? _____

Has menstration begun? (girls) _____

Is your child currently under the care of a physician? _____

If yes, state Doctors name _____

Please list all drugs your child is currently taking and for what purpose _____

Please list all drugs your child is allergic to _____

Does your child have a heart condition requiring antibiotic medication for dental work?

Has your child had any of the following medical problems:

Allergies _____ Diabetes _____

Asthma _____ Hepatitis, Jaundice _____

Sinus Infection _____ Glandular Disorders _____

Heart Trouble/Murmur _____ Rheumatic Fever _____

HIV virus/Aids _____ Other Medical Problems* _____

*If yes explain _____

I understand the information given today is correct and 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