



Child Information Card

Please print clearly!

Surname:..... First name:..... Preferred name:.....
Birthdate:...../...../..... Gender: M F Email:.....
Address:..... Suburb:..... Postcode:.....
Names and ages of brothers and sisters:.....
Hobbies/Sports/Interests:.....

Mother's name:.....
Home:..... Bus:..... Mobile:.....
Father's Name
Home:..... Bus:..... Mobile:.....
School:..... Year:..... Boarder? Y/N
Dentist:..... Referred by:..... Doctor:.....
Person responsible for account payment:..... Email:.....

Dental History

Yes No

- 1. Has there been an orthodontic consultation previously?
2. Any previous orthodontic treatment?
3. Has there been any injury to the jaws or teeth?
If so, what and when?.....
4. Do you know of any missing or extra permanent teeth?
5. Is there ever any facial or jaw joint pain?
6. Thumb or finger-sucking habit?
7. The date of last dental examination:.....
8. Reason for seeking an orthodontic opinion:.....



Please turn over



Patient's Name:.....

Medical History

Yes No

- 1. Is your child in good health? [] []
2. Is there a history of serious illness, accident or operation? [] []
Please list.....
3. Are there any medical problems being treated at this time? [] []
4. Is any medication currently being taken? [] []
Please list.....
5. Any allergies or drug sensitivities? [] []
Please list.....

6. Does your child have a history of any of the following? (Please answer Yes or No):

-Heart DiseaseEmotional ProblemsKidney Problems
.....Rheumatic FeverEpilepsy/ConvulsionsLearning Disability
.....EndocarditisFainting or DizzinessLiver Problems
.....Heart MurmurHearing ProblemsPneumonia
....."Hole" in the HeartBleeding DisordersAsthma
.....Cleft PalateBone DisordersSpeech Problems
.....DiabetesHepatitisTonsillitis
.....Endocrine ProblemsHIVTuberculosis
.....Broken BonesJoint prosthesis Arthritis
..... Other (please explain)

Because of the long-term nature of orthodontic treatment, it is important that you let us know of new medical conditions that may be diagnosed while your child is under our care.

Parent's Name

Parent's Signature

Date

