

Steven S. Sabatino DDS, MS, PLLC
Child History Form
Patient Information

Date: _____

Child Name: _____

Name Child prefers to be called: _____

Male: _____ Female: _____ Height: _____ Weight: _____ Date of Birth: _____ Age: _____

Child's Home Address: _____

City: _____ State: _____ Zip: _____

Child's Home Phone #: _____ Cell #: _____

School Child is attending: _____ Grade: _____

Special Interests Sports/Hobbies: _____ Musical Instrument: _____

Who may we thank for referring you to our Office? _____

Who is accompanying this child today? _____

Your relationship to Child: _____ Are you the responsible Party? _____

(Natural Parent?) Yes No (Child Adopted?) Yes No (Foster Parent?) Yes No

(Other - specify relationship _____)

Names & Ages of other Family Members: _____

Are any family members patients of Dr. Sabatino? _____

Emergency Contact (Nearest relative not living with you.) Name: _____

Relationship: _____ Work #: _____ Home #: _____

Mother

Marital Status Married Divorced Widow Single Remarried

Mother Stepmother Guardian Date of Birth _____

Social Security Number _____

Name _____

Work or Cell _____ Occupation _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

Employer _____ Employer Address: _____

Father

Marital Status Married Divorced Widow Single Remarried

Father Stepfather Guardian Date of Birth _____

Social Security Number _____

Name _____

Work or Cell _____ Occupation _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

Employer _____ Employer Address: _____

Orthodontic Insurance Information

Primary Insurance Information

Relationship to Patient _____

Insured's Name _____ Insured's Date of Birth _____

Insured's Social Security # _____ Employer's Name _____

Employer's Address _____ City _____ State _____ Zip _____

Insurance Company _____ City _____ State _____ Zip _____

Insurance Phone # _____ **Name of Dental Plan** _____

(We will need a copy of your "Dental Plan Insurance Card")

Secondary Insurance Information

Relationship to Patient _____

Insured's Name _____ Insured's Date of Birth _____

Insured's Social Security # _____ Employer's Name _____

Employer's Address _____ City _____ State _____ Zip _____

Insurance Company _____ City _____ State _____ Zip _____

Insurance Phone # _____ **Name of Dental Plan** _____

Dental History

Dentist: _____ Address _____ City _____ State _____ Zip _____

Date of last visit? _____ **What is your chief concern?** _____

Does the patient want orthodontic treatment? _____

Please circle the appropriate answer to the following questions, and explain if necessary.

- Yes No Do you have any type of thumb or tongue habit? _____
- Yes No Have you ever had speech therapy? If yes how long? _____
- Do you breathe mostly through the: nose _____ mouth _____ both _____ uncertain _____
- Yes No Have you ever had any abscessed teeth? _____
- Yes No Is any part of your mouth sensitive to temperature or pressure? _____
- Yes No Have you ever been informed of missing, extra or chipped teeth? _____
- Yes No Are you aware of clenching or grinding your teeth? _____
- Yes No Are you aware of jaw clicking or popping? _____
- Yes No Are your teeth or jaws ever uncomfortable when you awaken in the morning? _____
- Yes No Do you have any facial pain? _____
- Yes No Do you have any pain or soreness around your face, neck, or back? _____
- Yes No Do you have TMJ? _____
- Yes No Have you ever experienced chronic ringing in your ears? _____
- Yes No Do you have headaches? _____
- Yes No Have there ever been any injuries to the face, mouth or teeth? _____
- Yes No Do your gums bleed when you brush your teeth? _____
- Yes No Have you or anyone in your family had orthodontics? _____
- Yes No Does the patient resemble Mother and/or Father? _____
- Yes No Does anyone in the family have a similar dental condition? _____

Medical Information

Physician: _____ Date of last visit: _____ Phone: _____

Physician's Address: _____ City _____ State _____ Zip _____

Please circle Yes or No (If yes, please fill in the details.)

- Yes No Are you taking any medications? _____
- Yes No Are you allergic to any medications? _____
- Yes No Are you presently under care of a physician? _____
- Yes No Do you have history of a major illness? _____
- Yes No Have you ever had any major operations? _____
- Yes No Have you ever been hospitalized? _____
- Yes No Have you ever been involved in a serious accident? _____
- Yes No Have you had your tonsils or adenoids removed? _____
- Yes No Have you ever had any of the following: Asthma _____ Allergies _____ Hayfever _____ Throat infections _____

What are you allergic to? _____

Please circle the appropriate answer for the medical conditions below:

- | | | |
|--|---|--------------------------------|
| Yes No Abnormal bleed | Yes No Endocrine Problems | Yes No Liver Disease |
| Yes No Tuberculosis | Yes No Anemia | Yes No Epilepsy |
| Yes No Lung/Respiratory Disease | Yes No Aids | Yes No Arthritis |
| Yes No Glaucoma | Yes No HIV+ | Yes No Blood Disorders |
| Yes No Heart Murmur | Yes No Nervous Disorders | Yes No Contact Lenses |
| Yes No Prolonged Bleeding | Yes No Heart Problems | Yes No Pneumonia |
| Yes No Other _____ | Yes No Hepatitis - Type _____ | Yes No High Blood Pressure |
| Yes No Rheumatic Fever | If a child have you reached puberty? Yes No | |
| Yes No Bone/Joint Disorder | Yes No Hyperactive | Yes No Rheumatic Heart Disease |
| Yes No Cancer or Tumor | Yes No Dizziness/Fainting | Yes No Diabetes |
| Girls, have you started menstruation? Yes No | Yes No Thyroid Disease | Yes No Emotional Problems |
| Yes No Herpes | Yes No Sinusitis | |
| Yes No Kidney Involvement | | |
| Boys, has your voice changed? Yes No | | |

Benefits of Orthodontics; Aesthetics, Health and Function

Orthodontics is a service that provides an improvement in the appearance of the teeth, the general function of the teeth, and in general dental health. Teeth, gums and jaw are an intricate body part, and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime, and there can be some movement of the teeth, and some change after treatment. I hereby state that I have read and understand the above paragraph, and that I have truthfully to the best of my ability answered all of the above questions.

Patient/Parent Signature _____ Date _____