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_____ Email_____
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_____ Email_____
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:_____ Date of Last Visit: _____

Does the patient want orthodontic treatment?_____

What is your chief concern for todays visit? _____

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 Tuberculosis
Yes No Lung/Respiratory Disease
Yes No Glaucoma
Yes No Heart Murmur
Yes No Prolonged Bleeding
Yes No Other_____
Yes No Rheumatic Fever
Yes No Bone/Joint Disorder
Yes No Cancer or Tumor
Girls, have you started menstruation?..... Yes No
Yes No Herpes
Yes No Kidney Involvement
Boys, has your voice changed?..... Yes No

Yes No Endocrine Problems
Yes No Anemia
Yes No Aids
Yes No HIV+
Yes No Nervous Disorders
Yes No Heart Problems
Yes No Hepatitis – Type_____
If a child have you reached puberty?..... Yes No
Yes No Hyperactive
Yes No Dizziness/Fainting
Yes No Thyroid Disease
Yes No Sinusitis

Yes No Liver Disease
Yes No Epilepsy
Yes No Arthritis
Yes No Blood Disorders
Yes No Contact Lenses
Yes No Pneumonia
Yes No High Blood Pressure
Yes No Rheumatic Heart Disease
Yes No Diabetes
Yes No Emotional Problems

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_____