

**GARTNER ORTHODONTICS, LTD.
CHILD'S DENTAL/MEDICAL HISTORY**

Patient's Name _____ Date of Birth _____

DENTAL HISTORY (Circle the appropriate answers)

1. Name of dentist _____
Address _____ Tele. # _____
2. How long since the last visit to the dentist? _____
3. Does patient eat sweets such as candy, soda, chewing gum? Yes No
4. Does patient brush teeth upon rising? Yes No
When going to bed? Yes No
Right after eating meals? Yes No
5. Have any cavities been noted in the past? Yes No
6. Have there been any injuries to teeth such as falls, blows, chips, etc.? Yes No
If so, describe _____
7. How many children in family? _____
8. Has anyone, including parents, had orthodontic treatment? Yes No

MEDICAL HISTORY (Circle the appropriate answers)

1. Is patient in good health? Yes No
2. Is patient under care of physician? Yes No
If yes, since when and why? _____
3. Name of physician _____
Address _____ Tele. # _____
4. Has patient had any serious illness? Yes No
5. Has patient had surgery? Yes No
6. Does patient have allergies? Yes No
7. Is patient allergic to penicillin, antibiotics or other drugs? Yes No
8. Is patient receiving any medication? Yes No
If so, explain _____
9. Does the patient have a history of (circle appropriate responses) diabetes, heart trouble, asthma, kidney infection, toothache, ear infection, hepatitis, AIDS?

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PARENT/GUARDIAN SIGNATURE _____ DATE _____