JAMES T. HUTTA DDS
PRACTICE LIMITED TO ORTHODONTICS

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www.lovethatsmile.net

CHILD MEDICAL HISTORY FORM

Name			
Preferred Name		Sex	
DOB		Age	
Address			
City		State	Zip
Home Phone		Cell Phone	
Email			
Person Responsible For Financial Obligations			
Responsible Party SS#		Responsible Party DOB	
Dentist		Date of last exam	
Whom may we thank for referring you to our practice?			
School		Grade	
Mother's Name		DOB	SS#
Home Phone	Cell		Work
Address			
City		State	Zip
Email			
Employer		Length of employment	
Father's Name		DOB	SS#
Home Phone	Cell		Work
Address			
City		State	Zip
Email			
Employer		Length of employment	

DENTAL INSURANCE INFORMATION:

Primary	Secondary
Ins. Co.	Ins. Co.
Insured	Insured
SS#	SS#
Group#	Group#
Employer	Employer

EMERGENCY CONTACT:

Name	Phone	Relationship

DOES THE PATIENT HAVE A HISTORY OF ANY OF THE FOLLOWING? (CHECK WHEN YES)

☐ AIDS	☐ Hemophilia
☐ Anemia	☐ Hepatitis
☐ Asthma	☐ High Blood Pressure
☐ Blood Disorders	☐ Latex Sensitivity
☐ Bruise Easily	☐ Neurological Disorders
☐ Cerebral Palsy	☐ Respiratory Problems
☐ Diabetes	☐ Tonsil or Adenoid Removal
☐ Emotional Problems	☐ Tuberculosis
☐ Heart Murmur/Heart Problems	☐ Other

STATE ANY REASONS WHY THE PATIENT IS CURRENTLY UNDER THE CARE OF A PHYSICIAN

LIST ANY MEDICATIONS THAT THE PATIENT IS CURRENTLY TAKING

LIST ANY DRUG ALLERGIES OR SENSITIVITIES

HAS THE PATIENT BEEN ADVISED THAT ANTIBIOTICS SHOULD BE TAKEN PRIOR TO DENTAL PROCEDURES?
(YES OR NO)

LIST ANY OTHER SERIOUS ILLNESSES, OPERATIONS OR DISEASES NOT LISTED ABOVE

DEVELOPMENTAL HISTORY

HAS THE PATIENT REACHED PUBERTY? (YES OR NO) GIRLS; MENSTRUATION? (YES OR NO) BOYS; HAS VOICE CHANGED? (YES OR NO)

DENTAL HISTORY

DOES THE PATIENT HAVE A HISTORY OF ANY OF THE FOLLOWING? (CHECK WHEN YES)

☐ Bleeding Gums	☐ Mouth Breathing
☐ Clenching or Grinding of Teeth	☐ Nail Biting
☐ Difficulty Chewing or Swallowing	☐ Periodontal Surgery
☐ Injuries to Face or Teeth	☐ Permanent Teeth Removed
☐ Jaw Joint Pain	☐ Speech Problems
☐ Jaw Locking Open or Closed	☐ Sucks Thumb, Finger or Lip
☐ Limitation in Mouth Opening	☐ Teeth Sensitivity – Hot/Cold
☐ Missing or Extra Permanent Teeth	☐ Tongue Thrust

LIST ANY DENTAL CONCERNS WE SHOULD BE AWARE OF

HAS THE PATIENT RECEIVED AN EVALUATION OR TREATMENT IN ANOTHER ORTHODONTIC OFFICE? (YES OR NO)

IF YES, BY WHOM?

LIST YOUR CHIEF CONCERNS AND WHAT GOALS YOU WOULD LIKE TO ACCOMPLISH WITH ORTHODONTIC TREATMENT

AUTHORIZATION

I understand that the information I have given is correct to the best of my knowledge, and that it will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my medical or dental status. I authorize release of any information to insurance carriers and to other health care providers involved in my child's care. I authorize Dr. Hutta, and the dental staff to perform any necessary dental services that are needed during diagnosis and treatment. Records can be released for a fee of $200.00. I understand that where appropriate, credit bureau reports may be obtained.

SIGNATURE (IF MINOR, PARENT'S SIGNATURE) DATE