



John J. Metz DMD, MS

Is your child seeing a physician now? _____ Why? _____

Physician's Name: _____

Is your child taking any medications? () Yes () No If yes, please list

1. _____ 3. _____

2. _____ 4. _____

Has your child ever been hospitalized? () Yes () No If yes, please explain

Dental Health

Yes No

() () Has your child ever had a toothache?

() () Has your child ever received a blow to his/her teeth?

() () Does brushing cause his/her gums to bleed?

Why is your child here today? (Main orthodontic concern) _____

When was your child's last dental appointment? _____

Does your child think there is anything wrong with his/her teeth? () Yes () No

Has he/her begun puberty? () Yes () No

If patient is a girl, has menstruation begun? () Yes () No () n/a

If patient is a boy, has their voice changed or have facial hair? () Yes () No () n/a

Has the patient grown in the past year, or shoe size changed? () Yes () No

Has either biological parent had orthodontic treatment? () Yes () No

Is the child interested in orthodontic treatment? () Yes () No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform any necessary dental services that my child may need during diagnosis and treatment with my informed consent.

X _____

Signature of Parent/ Guardian

_____ Date