Welcome!

John J. Metz, DMD, MS

Kids & Teens Medical & Dental Health History Form

Child's Name ______________________ Date of Birth ____________

Parent 1: Name ____________ Cell# ____________ Relationship ____________ ☐

Occupation ____________ Employer ____________ Work phone ____________

Parent2: Name ____________ Cell# ____________ Relationship ____________ ☐

Occupation ____________ Employer ____________ Work phone ____________

Guardian: Name ____________ Cell# ____________ Relationship ____________ ☐

Occupation ____________ Employer ____________ Work phone ____________

Phone at Child's Primary Address ____________ Cell # for text message reminders ____________

Child's Primary Address ______________________

City ____________ State ____________ Zip ____________

Email ____________ Check box above for person responsible for account

Health History:

Does your child have, or has your child ever had, any of the following conditions:

Yes	No	
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Asthma
☐	☐	Bleeding Problems
☐	☐	Cancer
☐	☐	Cleft Lip & Palate
☐	☐	Delayed Speech Development
☐	☐	Developmentally Delayed
☐	☐	Diabetes
☐	☐	Emotional Disturbances
☐	☐	Fainting Spells
☐	☐	Hearing Loss/Impairment
☐	☐	Heart Condition

Yes	No	
☐	☐	Hyperactive
☐	☐	Infectious Diseases: (Circle)
		Herpes HIV Tuberculosis Hepatitis
☐	☐	Jaundice
☐	☐	Kidney Disease
☐	☐	Liver Disease
☐	☐	Pregnant
☐	☐	Psychiatric Problems
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Sickle Cell Anemia
☐	☐	Other ____________

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METZ ORTHODONTICS

John J. Metz, DMD, MS

Is your child currently seeing a physician? ________ 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 or injury 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

Maturation:

Yes	No	
☐	☐	Has he/she begun puberty?
☐	☐	If patient is a girl, has menstruation begun?
☐	☐	If patient is a boy, has his voice changed or does he have facial hair?
☐	☐	Has the patient grown in the last year, or shoe size changed?
☐	☐	Has either biological parent had orthodontic treatment?
☐	☐	Is the child interested in orthodontic treatment?

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.

Signature of Parent/Guardian ______________________________ Date ____________________