WELCOME!

DAVID L. WILKINSON D.D.S., M.S.
Orthodontics for Children and Adults

CHILD HEALTH HISTORY

ABOUT YOUR CHILD

TODAY'S DATE: ____________

Child's name: ____________ Birthdate: ____________ ☐ Male ☐ Female

Nickname: ____________ Home #: ____________

School: ____________ Grade: ____________

Home address: ____________ street city state zip

Whom may we thank for referring your child? ____________

PARENT

Parent's marital status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single

Mother's name: ____________ Birthdate: ____________

Home #: ____________ Work #: ____________ Employer: ____________

Social Security #: ____________ Home email: ____________ Length of employment: ____________

Home address: ____________ street city state zip

Father's name: ____________ Birthdate: ____________

Home #: ____________ Work #: ____________ Employer: ____________

Social Security #: ____________ Home email: ____________ Length of employment: ____________

Home address: ____________ street city state zip

INSURANCE INFORMATION

Primary Insurance: Orthodontic coverage? ☐ Yes ☐ No

Insurance Co. name: ____________ Phone #: ____________ Policy holder's birthdate: ____________

Social Security #: ____________ Insurance Co. address: ____________ street city state zip

Policy holder's name: ____________ Relationship: ____________ Group #: ____________

Policy #: ____________

Policy holder's employer: ____________ Employer's address: ____________ street city state zip

Secondary Insurance: Orthodontic coverage? ☐ Yes ☐ No

Insurance Co. name: ____________ Phone #: ____________ Policy holder's birthdate: ____________

Social Security #: ____________ Insurance Co. address: ____________ street city state zip

Policy holder's name: ____________ Relationship: ____________ Group #: ____________

Policy #: ____________

Policy holder's employer: ____________ Employer's address: ____________ street city state zip

Dr. David L. Wilkinson, D.D.S., M.S.
Orthodontics for children and adults

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DENTAL HISTORY

Is your child currently in pain? ☐ Yes ☐ No
Primary reason for today's visit: ______

Has your child experienced problems with past dental work? ☐ Yes ☐ No

Does your child brush his/her teeth daily? ______ Floss his/her teeth daily? ______

Current dentist: ______ Date of last visit: ______

Has an orthodontist been consulted previously? ☐ Yes ☐ No By whom? ______

Have there been any injuries to the face, mouth or teeth? ☐ Yes ☐ No

Does your child play any musical instruments? ☐ Yes ☐ No

Does/did your child have any of the following habits?

- ☐ Lip sucking/biting
- ☐ Nail biting
- ☐ Chewing on objects
- ☐ Clenching/grinding teeth
- ☐ Thumb/finger sucking
- ☐ Nursing bottle habits
- ☐ Tongue/cheek biting
- ☐ Used pacifier
- ☐ Tongue thrust
- ☐ Mouth breather
- ☐ Speech problems

MEDICAL HISTORY

Child's physician: ______ Phone #: ______ Date of last visit: ______

Address: ______
street city state zip

Is your child currently under the care of a physician? ☐ Yes ☐ No Please explain: ______

Describe your child's current physical health: ☐ Good ☐ Fair ☐ Poor Are immunizations current? ☐ Yes ☐ No

Please list all drugs that your child is currently taking: ______

Please list all drugs and/or things that cause your child allergic reactions: ______

Is your child taking fluoride? ☐ Yes ☐ No

Is antibiotic premedication needed before dental appointments? ☐ Yes ☐ No

Anything you would like to discuss with the doctor in private? ☐ Yes ☐ No

Has your child had/experienced any of the following?

- ☐ Abnormal bleeding
- ☐ Aids/HIV+
- ☐ Allergies
- ☐ Anemia
- ☐ Asthma
- ☐ Blood transfusion
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy/convulsions
- ☐ Handicaps/disabilities
- ☐ Hearing impairment
- ☐ Heart problems
- ☐ Hemophilia
- ☐ Hepatitus
- ☐ High blood pressure
- ☐ Hives/rash
- ☐ Hospital stay/operations
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Low blood pressure
- ☐ Lupus
- ☐ Measles
- ☐ Mitral valve prolapse
- ☐ Mononucleosis
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Severe/frequent headaches
- ☐ Sickle cell anemia
- ☐ Tonsilitis
- ☐ Tuberculosis (TB)

Please discuss any serious medical problems your child has had/experienced: ______

AUTHORIZATION

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary services that my child may need. I assign Dr. Wilkinson all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible and co-payment that my insurance does not cover. I understand that where appropriate, credit bureau reports may be obtained.

Signature: ______ Date: ______

Updated on: ______ date ______ date ______ date ______ date ______ date

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