Welcome!

ID No. _____
Model No. _____

Child Health History

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Patient Information

Date _____

Patient's Name _____
Last First Middle

Address _____
Street

_____
City State Zip

Home Phone _____ Birthdate _____

Soc. Sec. No. _____

Parent/Guardian's Name (if patient is a minor) _____

_____

School _____ Grade _____

Whom may we thank for referring you to our office?

_____

Other family members seen by our office _____

Responsible Party Information

Name _____

Home Address _____
Street

_____
City State Zip

How long at this address? _____

Home Phone _____ Work Phone _____

Cell Phone _____ E-mail _____

Previous Address (if less than 3 yrs.) _____
Street

_____
City State Zip

Soc. Sec. No. _____ Birthdate _____

Relationship to Patient _____

Employer _____ No. Years Employed _____

Occupation _____

Spouse's Name _____

Work Phone _____

Soc. Sec. No. _____ Birthdate _____

Relationship to Patient _____

Employer _____ No. Years Employed _____

Occupation _____

Dental Insurance Information

Insured's Name _____
Last First Middle

Relationship to Patient _____

Identification No./Soc. Sec. No. _____

Insurance Co. _____

Group No. _____ Phone _____

Insurance Co. Address _____
Street

_____
City State Zip

Do you have dual coverage? Y N

If yes, Insured's Name _____

Relationship to Patient _____

Identification No./Soc. Sec. No. _____

Insurance Co. _____

Group No. _____ Phone _____

Insurance Co. Address _____
Street

_____
City State Zip

Your Child's Dentist

Previous/Present Dentist _____

_____

Last Visit Date _____

Emergency Information

Name of nearest relative not living with you

_____
Last First Middle

Address _____
Street

_____
City State Zip

Home Phone _____ Work Phone _____

I understand that where appropriate, credit bureau reports may be obtained.

X _____ _____
Signature (Parent's signature if minor) Date

WHEELER ORTHODONTICS

4568 Feather River Drive, Suite D • Stockton, CA 95219
Phone: 209/951-0151 • Fax: 209/951-1235 • www.wheelerortho.com

Dental History

What is the reason for this visit? _____

_____

Has your child ever had a serious/difficult problem associated with any previous dental work? Y N

Does your child now/has your child ever experienced pain/discomfort in his/her jaw joint (TMJ/TMD)? Y N

How would you describe your child's current dental health? Good Fair Poor

Does your child like his/her smile? Y N Do your child's gums bleed? Y N

How many times a week does your child floss?_____

How many times a week does your child brush?_____

Has your child inherited any facial/dental characteristics? Y N

If yes, explain _____

_____

Medical History

Physician's Name _____ Last Visit Date_____

How would you describe your child's current physical health? Good Fair Poor

Explain _____

Have your child's tonsils/adenoids been removed? Y N

Is your child taking any prescription/over-the-counter drugs? Y N

Please list each one _____

For Women Is your child taking birth control pills? Y N

Is your child pregnant? Y N Week No. _____

Is your child nursing? Y N

Has your child ever had any of the following diseases/medical conditions?

Y N Heart Attack/Stroke	Y N Psychiatric Problems	Y N Cancer/Chemotherapy
Y N Epilepsy/Seizures/Fainting	Y N Heart Murmur	Y N Diabetes
Y N Rheumatic Fever	Y N Drug/Alcohol Abuse	Y N HIV+/AIDS
Y N Venereal Disease	Y N Heart Surgery/Pacemaker	Y N Hemophilia/Abnormal Bleeding
Y N Shingles	Y N Ulcers/Colitis	Y N Mitral Valve Prolapse
Y N Congenital Heart Defect	Y N Kidney Problems	Y N Anemia/Radiation Treatment
Y N Artificial Bones/Joints	Y N Asthma	Y N Artificial Valves
Y N Difficulty Breathing	Y N Sinus Problems	Y N Hospitalization
Y N High/Low Blood Pressure	Y N Hepatitis	Y N Fever Blisters
Y N Blood Transfusion	Y N Severe/Frequent Headaches	Y N Emphysema/Glaucoma
Y N Arthritis	Y N Tuberculosis (TB)	

Please list any serious medical condition not listed above that you have ever had

_____

Do you need to be premedicated with antibiotics? Y N

Is your child allergic to any of the following?

Y N Penicillin	Y N Erythromycin	Y N Dental Anesthetics	Y N Codeine
Y N Aspirin	Y N Tetracycline	Y N Latex	Y N Nickel/Metals

Please list any other drugs/materials that your child is allergic to _____

_____

Does your child have any of the following habits?

Y N Thumb/Finger Sucking Y N Lip Sucking/Biting Y N Nail Biting Y N Nursing Bottle Habits

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

American Association of Orthodontists

www.wheelerortho.com

Dr. Wheeler's Notes

Problem _____

_____

Class Right
Molar I EO II III **Canine** I EO II III

Class Left
Molar I EO II III **Canine** I EO II III

Overbite Open Slight Moderate Deep _____ %

Overjet Negative Slight Moderate Severe _____ mm

Upper Arch
Spacing Mild Moderate Severe Central Diastema
Crowding Mild Moderate Severe
Arch Form Broad Ovoid Constricted Omega V

Lower Arch
Spacing Mild Moderate Severe
Crowding Mild Moderate Severe
Arch Form Broad Ovoid Constricted Omega V

Crossbite
Unilateral R L Bilateral Individual Tooth No._____

Midlines ——|——

Curve of Spee Flat Mild Moderate Deep Reverse

Curve of Wilson Flat Accentuated

TMJ **Noises** R L **Pain** R L **Hx of Locking** Open Closed

Habits Thumb Sucking Tongue Thrusting Lip Biting Nail Biting

Pano Evaluation
Missing Teeth **Impacted Teeth**

Anomalies _____ **Short Roots**

Treatment

Bond 6-6	Hyrax/RPE	
Bond Upper 6-6/Lower 7-7	Bluegrass	
Bond 7-7	TMJ Splint	
Band 6's/Bond 5-5	RPHG	
Band 6's and 7's/Bond 5-5	BDA	LLA
Band 6's/Bond 2-2	Nance	ULA

Other_____

Brackets Stainless Ceramic Ceramic Upper/Metal Lower Gold

Referrals

Extractions/Restorative Needs

	8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8	
R	1	2	3	4	5	6	7	8		9	10	11	12	13	14	15	16	L
	32	31	30	29	28	27	26	25		24	23	22	21	20	19	18	17	
	8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8	

Permanent

	E	D	C	B	A		A	B	C	D	E
R	A	B	C	D	E		F	G	H	I	J
	T	S	R	Q	P		O	N	M	L	K
	E	D	C	B	A		A	B	C	D	E

L

Primary

Perio/Surgical Hygiene _____ Frenectomy_____
Gingival Grafting _____ Expose/Bond No._____

DDI

Treatment _____ months **Recall** _____ months

Fee _____

_____