Medical & Dental History
Child or Teen
(under age 18)

Please complete this form with as much detail as possible. This confidential information will become a part of our patient records.

Today's Date ______________________ ☐ Male ☐ Female

Child's Full Legal Name ______________________ Preferred Name ______________________

Date of Birth ______________ Age _____ School ______________________ Grade ________

Address ____
Street City State Zip

E-mail Address ______________________ Home Phone ______________________

Personal Interests or Hobbies ______________________

Name and Birthdate of Siblings ______________________

Whom may we thank for referring you to our office? ______________________

Contact Information

☐ Mother ☐ Stepmother ☐ Guardian Other________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Name ______________________

Address ______________________
(If different than child's) Street

____
City State Zip

Home Phone ______________________

Cell Phone ______________________

Email ______________________

Birth Date ______________________

Social Security Number ______________________

Employer ______________________

Occupation ______________________

Work Phone ______________________

☐ Father ☐ Stepfather ☐ Guardian Other________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Name ______________________

Address ______________________
(If different than child's) Street

____
City State Zip

Home Phone ______________________

Cell Phone ______________________

Email ______________________

Birth Date ______________________

Social Security Number ______________________

Employer ______________________

Occupation ______________________

Work Phone ______________________

If divorced or separated, who is the Custodial Parent? ☐ Mother ☐ Father ☐ Joint

Dental Insurance Information

Primary: Subscriber's Name ______________________
Relationship to Patient

Employer ______________________ Insurance Name ______________________

Secondary: Subscriber's Name ______________________
Relationship to Patient

Employer ______________________ Insurance Name ______________________

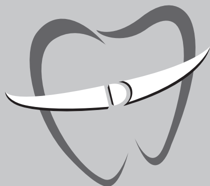
Please allow us to make copies of your insurance cards.

Emergency Information

Name of nearest relative not living with you ______________________ Relationship ____________

Address ______________________ **Phone** ______________________

PLEASE COMPLETE BOTH SIDES AND FEEL FREE TO ASK ANY QUESTIONS



DOWNEY ORTHODONTICS
Dr. Nathan M. Downey
Specialist in Orthodontics for Children, Teens and Adults
419-352-8453
www.downeybraces.com

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Dental History

Child's Dentist ______________________________ Date of last exam ____________

Has child been to an orthodontist before? ☐ Yes ☐ No

Have other family members had orthodontic treatment? ☐ Yes ☐ No

What are the main concerns you have about your child's teeth? ______________________________

Yes	No	
☐	☐	Does/did your child suck their thumb/finger?
☐	☐	Does your child suck/bite their lip?
☐	☐	Does your child breathe through their mouth?
☐	☐	Does your child have speech problems?
☐	☐	Has your child had any injuries to the face, mouth, or teeth?
☐	☐	Does your child have any "gum" problems?
☐	☐	Has your child been informed of any missing/extra teeth?
☐	☐	Does your child clench/grind teeth?
☐	☐	Does your child have headaches?
☐	☐	Does your child have pain when opening or closing their mouth?
☐	☐	Has your child had a negative reaction to dental or medical care?

Medical History

Medical Doctor ______________________________ Date of last exam ____________

Under care of doctor now? ☐ Yes ☐ No Phone Number ____________________

Medications being taken now ______________________________

Has your child experienced:

Yes	No	
☐	☐	Blood Disorders
☐	☐	Drug Allergies
☐	☐	Allergies to latex/metals
☐	☐	Allergies to plastic
☐	☐	Any operations
☐	☐	Asthma
☐	☐	Cancer
☐	☐	Convulsions/Epilepsy
☐	☐	Diabetes
☐	☐	Hearing Impairment
☐	☐	Hepatitis
☐	☐	HIV / AIDS
☐	☐	Kidney/Liver Problems
☐	☐	Rheumatic/Scarlet Fever
☐	☐	Tuberculosis
☐	☐	Congenital Heart Defect
☐	☐	Heart Murmur
☐	☐	ADHD

Are there any medical conditions not listed above that you feel we need to be aware of? ____________________

____

Is antibiotic premedication required before dental procedures? ☐ Yes ☐ No

Please discuss any medical problems that your child has that might have an effect on his/her treatment in our office:

____

For growth purposes, has your child gone through puberty? ☐ Yes ☐ No ☐ Just Beginning

Has menstration begun (girls)? ☐ Yes ☐ No Are you pregnant (girls)? ☐ Yes ☐ No

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

____________________ ____________________ ____________
Signature Print Name Date

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

Thank you for the trust and confidence you've placed in me to take care of your orthodontic needs.

- Nathan M. Downey, DDS, MS

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