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(304) 645-2088

Date: _____

Child's Name: _____
Last First Middle

Nickname: _____ Date of Birth: _____

Age: _____ Sex: _____ School: _____ Grade: _____

Child's Home Address: _____ Home Phone: _____
E-mail: _____

Child's Hobbies: _____

Parent's Marital Status(circle one): Married Divorced Widowed Single
Person Responsible for Account: _____

Father's Information

Name: _____
Home Address: _____
Home Phone: _____
Cell Phone: _____
E-mail: _____
Occupation: _____
Business: _____
Work Phone: _____

Mother's Information

Name: _____
Home Address: _____
Home Phone: _____
Cell Phone: _____
E-mail: _____
Occupation: _____
Business: _____
Work Phone: _____

In the event we must reach a parent during the work day, is it permissible to call you at work?
Yes No Or what is the best way to contact a parent? _____

Orthodontic Insurance Coverage? **Yes No** Insurance Company _____

Have we treated other siblings or family members? **Yes No**
Names of family members we treated? _____
Names and ages of other children in the family? _____

Family Health Team:

Family Dentist: _____ Physician: _____
Oral Surgeon: _____ Pharmacy: _____

Does your child have any of the following habits?

Yes No	Clenching/ grinding teeth	Yes No	Speech problems
Yes No	Lip sucking/ nail biting	Yes No	Thumb/ finger sucking
Yes No	Mouth breathing	Yes No	Tongue thrust

Medical History

Is your child in good health today?	Yes	No
Does your child have any history of major illnesses?	Yes	No
Have your child's tonsils and/or adenoids been removed?	Yes	No
Has your child reached puberty?	Yes	No
Does your child have a tendency for Colds? Sore throats? Ear infections?		
List any prescription and/or over-the-counter drugs now being taken.		

List any allergies or drug sensitivities. _____

Has your child ever had any of these problems?	Yes	No	Diabetes
Yes	No	Yes	No
Abnormal bleeding	Yes	No	Handicaps/disabilities
Yes	No	Yes	No
Allergy to drugs	Yes	No	Hearing impairment
Yes	No	Yes	No
Allergy to latex/ metal	Yes	No	Heart murmur
Yes	No	Yes	No
Allergy to plastic	Yes	No	Hemophilia
Yes	No	Yes	No
Any hospital stays	Yes	No	Hepatitis
Yes	No	Yes	No
Any operations	Yes	No	HIV +/- AIDS
Yes	No	Yes	No
Asthma	Yes	No	Kidney/ liver problems
Yes	No	Yes	No
Cancer	Yes	No	Tuberculosis (TB)
Yes	No	Yes	No
Congenital heart defect	Yes	No	Anything you would like to discuss in private
Yes	No		
Convulsion/ epilepsy			

Please discuss any medical problems you think we should know about your child. _____

Dental History

What concerns lead you and your child to seek an orthodontic evaluation?

Does your child require antibiotic coverage before dental treatment?	Yes	No
Has your child ever been evaluated or had orthodontic treatment before?	Yes	No
Has your child had any injuries to the face, mouth, or teeth?	Yes	No
Have you ever been informed that your child has extra or missing teeth?	Yes	No
Have either parent had orthodontic treatment?	Yes	No

I understand that the information that I have given is correct to the best of my knowledge, that it will be kept confidential, and that it is my responsibility to inform this office of changes in my child's medical or dental status. I authorize the orthodontic staff to perform the necessary dental/orthodontic services my child may need.

Signature: _____ **Date:** _____

Drs. McClung and Hamilton occasionally give lectures and presentations to consulting dentists, orthodontists, and other health care professionals. The materials used may include patient histories, photos, and x-rays. Complete patient privacy would be maintained and information would be anonymous. Your signature below would allow them to use your child's orthodontic records for educational use only.

Signature: _____ **Date:** _____