Laura L. Willhoite, D.D.S.

Specialist in Orthodontics

Dental and Medical History for_____

General Dentist_____Last Check-Up_____/_____/___

Has your child ever been evaluated for orthodontic treatment? ☐Yes ☐No

Is your child presently in a rapid growth time? ☐Yes ☐No

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

If yes, explain_____

Is your child under the care of a physician? ☐Yes ☐No

If yes, state Doctor's Name_____

Please list all drugs your child is currently taking and for what purpose:

_____

_____

Does your child have a heart condition requiring pre-medication with antibiotics prior to dental work? ☐Yes ☐No_____

Is child allergic to nickel? ☐Yes ☐No

Is child allergic to latex? ☐Yes ☐No

Has your child exhibited any of the following habits in the past (mark with X) or still exhibit these habits now (mark with O)?

Mouth Breathing	_____	Thumb Sucking	_____	Finger Sucking	_____
Grinding Teeth	_____	Lip Biting	_____	Thrusting	_____
Clenching Teeth	_____	Nail Biting	_____		

Has your child had any of the following medical problems:

Allergies	_____	Hepatitis / Jaundice	_____	HIV / AIDS	_____
Asthma	_____	Heart Trouble	_____	Other	_____
Sinus Infection	_____	Glandular Disorder	_____		
Diabetes	_____	Rheumatic Fever	_____		

I state that the information given above is correct. I understand that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status.

Signature_____Date_____/_____/_____