Steven S. Sabatino DDS, MS, PLLC
Child History Form
Patient Information

Date:_____

Child Name:_____

Name Child prefers to be called:_____
Male:_____ Female:_____ Height:_____ Weight:_____ Date of Birth:_____ Age:_____
Child's Home Address:_____
City:_____ State:_____ Zip:_____
Child's Home Phone#: _____ Cell #:_____
School Child is attending:_____ Grade:_____
Special Interests Sports/Hobbies:_____ Musical Instrument:_____
Who may we thank for referring you to our Office?_____
Who is accompanying this child today?_____
Your relationship to Child:_____ Are you the responsible Party?_____
(Natural Parent?) __Yes __No) (Child Adopted? __Yes __No) (Foster Parent? __Yes __No)
(Other – specify relationship_____)
Names & Ages of other Family Members:_____
_____
Are any family members patients of Dr. Sabatino?_____
Emergency Contact (Nearest relative not living with you.) Name:_____
Relationship:_____ Work #:_____ Home #:_____

Mother_____ **Father**_____
Marital Status __Married __Divorced __Widow __Single __Remarried
__ Mother __ Father __ Stepparent __ Guardian Date of Birth_____
Social Security Number_____ Email_____
Name_____
Work or Cell_____ Occupation_____
Address_____
City_____State_____Zip_____Home Phone_____
Employer_____Employer Address:_____

Mother_____ **Father**_____
Marital Status __Married __Divorced __Widow __Single __Remarried
__ Mother __ Father __ Stepparent __ Guardian Date of Birth_____
Social Security Number_____ Email_____
Name_____
Work or Cell_____ Occupation_____
Address_____
City_____State_____Zip_____Home Phone_____
Employer_____Employer Address:_____

Orthodontic Insurance Information

Primary Insurance Information Relationship to Patient_____
Insured's Name_____ Insured's Date of Birth_____
Insured's Social Security #_____ Employer's Name_____
Employer's Address_____ City_____ State_____ Zip_____
Insurance Company_____ City_____ State_____ Zip_____
Insurance Phone #_____ **Name of Dental Plan**_____

(We will need a copy of your "Dental Plan Insurance Card")

Secondary Insurance Information Relationship to Patient_____
Insured's Name_____ Insured's Date of Birth_____
Insured's Social Security #_____Employer's Name_____
Employer's Address_____ City_____ State_____ Zip_____
Insurance Company_____ City_____ State_____ Zip_____
Insurance Phone #_____ **Name of Dental Plan**_____

Dental History

Dentist:_____ Date of Last Visit: _____

Does the patient want orthodontic treatment?_____

What is your chief concern for todays visit? _____

Please circle the appropriate answer to the following questions, and explain if necessary.

Yes No Do you have any type of thumb or tongue habit?_____
Yes No Have you ever had speech therapy? If yes how long?_____
Do you breathe mostly through the: nose_____ mouth_____ both _____ uncertain _____
Yes No Have you ever had any abscessed teeth?_____
Yes No Is any part of your mouth sensitive to temperature or pressure?_____
Yes No Have you ever been informed of missing, extra or chipped teeth?_____
Yes No Are you aware of clenching or grinding your teeth?_____
Yes No Are you aware of jaw clicking or popping?_____
Yes No Are your teeth or jaws ever uncomfortable when you awaken in the morning?_____
Yes No Do you have any facial pain?_____
Yes No Do you have any pain or soreness around your face, neck, or back?_____
Yes No Do you have TMJ?_____
Yes No Have you ever experienced chronic ringing in your ears?_____
Yes No Do you have headaches?_____
Yes No Have there ever been any injuries to the face, mouth or teeth?_____
Yes No Do your gums bleed when you brush your teeth?_____
Yes No Have you or anyone in your family had orthodontics?_____
Yes No Does the patient resemble Mother and/or Father?_____
Yes No Does anyone in the family have a similar dental condition?_____

Medical Information

Physician:_____ Date of last visit:_____ Phone:_____
Physician's Address:_____ City_____ State_____ Zip_____

Please circle Yes or No (If yes, please fill in the details.)

Yes No Are you taking any medications?_____
Yes No Are you allergic to any medications?_____
Yes No Are you presently under care of a physician?_____
Yes No Do you have history of a major illness?_____
Yes No Have you ever had any major operations?_____
Yes No Have you ever been hospitalized?_____
Yes No Have you ever been involved in a serious accident?_____
Yes No Have you had your tonsils or adenoids removed?_____
Yes No Have you ever had any of the following: Asthma____ Allergies____ Hayfever____ Throat infections____
What are you allergic to?_____

Please circle the appropriate answer for the medical conditions below:

Yes	No	Abnormal bleed	Yes	No	Endocrine Problems	Yes	No	Liver Disease
Yes	No	Tuberculosis	Yes	No	Anemia	Yes	No	Epilepsy
Yes	No	Lung/Respiratory Disease	Yes	No	Aids	Yes	No	Arthritis
Yes	No	Glaucoma	Yes	No	HIV+	Yes	No	Blood Disorders
Yes	No	Heart Murmur	Yes	No	Nervous Disorders	Yes	No	Contact Lenses
Yes	No	Prolonged Bleeding	Yes	No	Heart Problems	Yes	No	Pneumonia
Yes	No	Other_____	Yes	No	Hepatitis – Type_____	Yes	No	High Blood Pressure
Yes	No	Rheumatic Fever	If a child have you reached puberty?.....			Yes	No	
Yes	No	Bone/Joint Disorder	Yes	No	Hyperactive	Yes	No	Rheumatic Heart
Yes	No	Cancer or Tumor	Yes	No	Dizziness/Fainting			Disease
Girls, have you started menstruation?.....			Yes	No		Yes	No	Diabetes
Yes	No	Herpes	Yes	No	Thyroid Disease	Yes	No	Emotional Problems
Yes	No	Kidney Involvement	Yes	No	Sinusitis			
Boys, has your voice changed?.....			Yes	No				

Benefits of Orthodontics; Aesthetics, Health and Function

Orthodontics is a service that provides an improvement in the appearance of the teeth, the general function of the teeth, and in general dental health. Teeth, gums and jaw are an intricate body part, and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime, and there can be some movement of the teeth, and some change after treatment. I hereby state that I have read and understand the above paragraph, and that I have truthfully to the best of my ability answered all of the above questions.

Patient/Parent Signature_____ Date_____