

**Dr. Eva Berka** *Certified Specialist in Orthodontics*  
**CHILD HEALTH HISTORY FORM**

PATIENT'S NAME \_\_\_\_\_ DATE \_\_\_\_\_

SEX \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ GRADE \_\_\_\_\_ SCHOOL \_\_\_\_\_

ADDRESS \_\_\_\_\_ POSTAL CODE \_\_\_\_\_ HOME PHONE \_\_\_\_\_

FATHER'S NAME \_\_\_\_\_ FATHER'S WORK PHONE \_\_\_\_\_ FATHER'S EMPLOYER \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_ MOTHER'S WORK PHONE \_\_\_\_\_ MOTHER'S EMPLOYER \_\_\_\_\_

FATHER'S CELL PHONE \_\_\_\_\_ MOTHER'S CELL PHONE \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_

FATHER'S ADDRESS: AS ABOVE? Y  N  MOTHER'S ADDRESS: AS ABOVE? Y  N  IF DIFFERENT, PLEASE SPECIFY \_\_\_\_\_

SIBLINGS: NAMES AND AGES \_\_\_\_\_

Have we treated any other family member? Y  N  If so, please list names: \_\_\_\_\_

Do you have general dental insurance? Y  N  Do you have orthodontic insurance? Y  N

Patient's dentist: \_\_\_\_\_ Patient's Physician \_\_\_\_\_

Whom may we thank for referring you to our practice? \_\_\_\_\_

Please list any favourite sports or hobbies: \_\_\_\_\_

Person Financially Responsible: Mother  Father  Both Parents

What is your reason for arranging an orthodontic consultation? \_\_\_\_\_

Has any family member a similar bite or jaw problem? Y  N

Has the patient previously worn any orthodontic appliance such as retainers, braces, spacers etc: Y  N

Has the patient sucked thumb or finger? Y  N

When did it stop? \_\_\_\_\_

Have tonsils or adenoids been removed? Y  N

Difficulty breathing through nose? Y  N  Unusual number of headaches? Y  N

Do your jaws click, crack or lock upon opening? Y  N

Do you grind or clench your teeth? Y  N

Do you have any of the following? (Please circle yes or no)

<b>Asthma</b>	<b>Yes</b>	<b>No</b>
Hayfever	Yes	No
Bleeding Disorder	Yes	No
Hepatitis	Yes	No
Mononucleosis	Yes	No
Rheumatic Fever	Yes	No
Epilepsy	Yes	No
Diabetes	Yes	No
Kidney Disease	Yes	No
Liver Disease	Yes	No
Heart Problems	Yes	No
Latex Allergy	Yes	No
HIV	Yes	No

Is the patient under a physician's care? Y  N

Is the patient taking any medication? Y  N

Does the patient have any allergies or drug reactions? Y  N  If so, please describe:

Any additional comments?

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Our privacy protocols comply with privacy legislation, standards of our regulatory body, the Royal College of Dental Surgeons of Ontario and the law. Only necessary information is collected and we only share information with your consent.

I hereby consent that Dr. Berka or her designated staff may release any information pertaining to orthodontic treatment to my dentist or related health professional:

Date \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_