Hillsborough
Pediatric Dentistry

ORTHODONTICS HEALTH HISTORY FORM

Name: Date:

What are the main concerns that you would like the orthodontist to accomplish?

Has your child ever been evaluated or had orthodontic treatment before? If yes, where?

Have there been any injuries to the face, mouth, teeth or chin? yes or no

List any musical instruments played:

Have adenoids or tonsils been removed? If yes, When?

Has your child been informed of any missing or extra permanent teeth? yes or no

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? yes or no

Does/did the child have any of the following habits?

Y	N	Lip Sucking/Biting	Y	N	Nursing Bottle Habits
Y	N	Nail Biting	Y	N	Thumb/Finger Sucking

Has puberty begun? yes or no

Has menstruation begun? (girls) yes or no

General Dentist:

Whom may we thank for referring you?