

**CHILD HISTORY FORM for Dr. Jay Galati DDS, MSD, PC**

Date \_\_\_\_\_

Child's full name \_\_\_\_\_  
Male \_\_\_\_\_ Female \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Child's home address \_\_\_\_\_ Zip \_\_\_\_\_  
School child attends \_\_\_\_\_ Grade \_\_\_\_\_  
Special interests/Hobbies \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_  
Who is the patient's General Dentist? \_\_\_\_\_

Who is financially Responsible for the account?  
Mother \_\_\_\_\_, Father \_\_\_\_\_, Both \_\_\_\_\_, Other \_\_\_\_\_

Mother's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
\_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widow \_\_\_\_\_ Single \_\_\_\_\_ Remarried  
\_\_\_\_\_ Step-mom \_\_\_\_\_ Guardian  
Address \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_  
Employer \_\_\_\_\_ Address \_\_\_\_\_  
Occupation \_\_\_\_\_ Work phone \_\_\_\_\_  
Drivers License #: \_\_\_\_\_ State: \_\_\_\_\_ SSN: \_\_\_\_\_  
Email Address: \_\_\_\_\_

Father's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
\_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widow \_\_\_\_\_ Single \_\_\_\_\_ Remarried  
\_\_\_\_\_ Step-Dad \_\_\_\_\_ Guardian  
Address \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_  
Employer \_\_\_\_\_ Address \_\_\_\_\_  
Occupation \_\_\_\_\_ Work phone \_\_\_\_\_  
Drivers License #: \_\_\_\_\_ State: \_\_\_\_\_ SSN: \_\_\_\_\_  
Email Address: \_\_\_\_\_

**ORTHODONTIC INSURANCE INFORMATION**

Primary insurance information: Insured's Name \_\_\_\_\_  
Social security number \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Phone Number \_\_\_\_\_  
Place of Employment \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Group number \_\_\_\_\_ ID Number \_\_\_\_\_

**WE WILL NEED A COPY OF DENTAL PLAN INSURANCE CARD**

## DENTAL AND MEDICAL HISTORY

Patients Name: \_\_\_\_\_

Please circle yes or no and give any details:

Yes No Are you taking any medications now? Please list: \_\_\_\_\_

\_\_\_\_\_

Yes No Are you allergic to any medications? \_\_\_\_\_

Yes No Do you have a history of a major illness? \_\_\_\_\_

Yes No Have you ever had speech therapy? If yes, how long? \_\_\_\_\_

Yes No Is any part of your mouth sensitive to temperature or pressure? \_\_\_\_\_

Yes No Do you have TMJ? \_\_\_\_\_ Any joint noise? \_\_\_\_\_

Yes No Any Pre-med required before seeing patient in dental chair? \_\_\_\_\_

Please circle the appropriate answer for medical conditions below:

Yes No AIDS

Yes No Allergies

Yes No Anemia

Yes No Artificial Joints

Yes No Asthma

Yes No Arthritis

Yes No Behavioral Disorder

Yes No Blood Clots

Yes No Blood Disease

Yes No Cancer or Tumor

Yes No Dizziness/Fainting

Yes No Diabetes

Yes No Epilepsy

Yes No Excessive Bleeding

Yes No Hay Fever

Yes No Heart Murmur

Yes No Hepatitis

Yes No High Blood Pressure

Yes No Mental Disorder

Yes No Nervous Disorder

Yes No Radiation Treatment

Yes No Respiratory Problems

Yes No Rheumatism

Yes No Stroke

Yes No Tuberculosis

Yes No Thyroid Disease

Yes No Allergy to Codeine/Penicillin

Yes No Any trauma to face, jaw or teeth

Explain \_\_\_\_\_

Benefits of orthodontics include aesthetics, health, and function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are intricate body parts 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 teeth and some changes after treatment.

By signing below, I am stating that I have read and fully understand the above. I also recognize that my diagnostic records and my name may be used for educational and promotional purposes. I truthfully answered all of the above questions to the best of my knowledge and agree to inform this office of any changes in my medical, dental, or family history. In addition, I hereby authorize Dr. Jay R. Galati to perform a complete orthodontic evaluation.

\_\_\_\_\_  
Signature of patient, parent or guardian

\_\_\_\_\_  
Date