

Patient Number: \_\_\_\_\_ Date: \_\_\_\_\_

# TINGRINNERS CLUB JAMAICA

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## CHILD/ADOLESCENT ORTHODONTIC CONSULTATION

Patient's Name: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Address: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Bus.Phone: \_\_\_\_\_ Father's Occupation: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Bus.Phone: \_\_\_\_\_ Mother's Occupation: \_\_\_\_\_

Parent's Marital Status: \_\_\_\_\_

Who will be responsible for this account? \_\_\_\_\_

In your own words, what is the problem? \_\_\_\_\_

### **MEDICAL HISTORY**

Name of child's physician: \_\_\_\_\_

Address of physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last examination: \_\_\_\_\_

Is your child in good health? .....Yes No Don't know

Does your child have a health problem? .....Yes No Don't know

If "yes" explain: \_\_\_\_\_

\_\_\_\_\_

Has your child ever been hospitalized, had general anesthesia, or emergency room visits?

Yes No Don't know

If "yes" explain: \_\_\_\_\_

\_\_\_\_\_

Are your child's immunizations up to date? .....Yes No Don't know

Allergies (Please list) \_\_\_\_\_

\_\_\_\_\_

Past medication taken by child: \_\_\_\_\_

\_\_\_\_\_

Daily medication child is now taking: \_\_\_\_\_

\_\_\_\_\_

Has your child ever had or been treated by a physician for: (Please circle your response)

- |                                |     |    |            |
|--------------------------------|-----|----|------------|
| Problems at Birth? .....       | Yes | No | Don't know |
| Diabetes? .....                | Yes | No | Don't know |
| Heart murmur? .....            | Yes | No | Don't know |
| Arthritis? .....               | Yes | No | Don't know |
| Heart Disease? .....           | Yes | No | Don't know |
| Cancer? .....                  | Yes | No | Don't know |
| Rheumatic Fever? .....         | Yes | No | Don't know |
| Cerebral Palsy? .....          | Yes | No | Don't know |
| Anaemia? .....                 | Yes | No | Don't know |
| Seizures? .....                | Yes | No | Don't know |
| Sickle Cell Anaemia? .....     | Yes | No | Don't know |
| Asthma? .....                  | Yes | No | Don't know |
| Bleeding/Haemophilia? .....    | Yes | No | Don't know |
| Cleft Palate/Lip? .....        | Yes | No | Don't know |
| Tonsil/Adenoid Problems? ..... | Yes | No | Don't know |
| Speech/Hearing Problems? ....  | Yes | No | Don't know |
| Transfusion? .....             | Yes | No | Don't know |
| Hepatitis? .....               | Yes | No | Don't know |



AIDS/HIV? .....	<b>Yes</b>	<b>No</b>	<b>Don't know</b>
Skin Problems? .....	<b>Yes</b>	<b>No</b>	<b>Don't know</b>
Tuberculosis? .....	<b>Yes</b>	<b>No</b>	<b>Don't know</b>
Sleep Problems? .....	<b>Yes</b>	<b>No</b>	<b>Don't know</b>
Liver Disease? .....	<b>Yes</b>	<b>No</b>	<b>Don't know</b>
Kidney Problems? .....	<b>Yes</b>	<b>No</b>	<b>Don't know</b>
Emotional/Behaviour Problems? ...	<b>Yes</b>	<b>No</b>	<b>Don't know</b>
Eye Problems? .....	<b>Yes</b>	<b>No</b>	<b>Don't know</b>

If "yes" to any of the above questions, please explain this or any other problem:

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Has your child had any recent rapid growth? \_\_\_\_\_

If so, how much? \_\_\_\_\_

**PARENTS:** Father (Height) \_\_\_\_\_ (Weight) \_\_\_\_\_

Mother (Height) \_\_\_\_\_ (Weight) \_\_\_\_\_

**SIBLINGS:** 1. (Height) \_\_\_\_\_ (Weight) \_\_\_\_\_

2. (Height) \_\_\_\_\_ (Weight) \_\_\_\_\_

**FEMALES:** Has menstruation begun? .... **Yes No**

If yes, when? \_\_\_\_\_

Pregnant? ... **Yes No**

**DENTAL HISTORY**

Has your child seen a Dentist before? \_\_\_\_\_

Date of last visit: \_\_\_\_\_

Regular Dentist's name: \_\_\_\_\_

- Has your child ever experienced any complications following dental treatment? **Yes No Don't know**
- Has your child had cavities and/or toothaches? **Yes No Don't know**
- Are your child's teeth sensitive to temperature or food? **Yes No Don't know**
- Did your child ever get instruction on brushing? **Yes No Don't know**
- Do your child's gums bleed when brushing? **Yes No Don't know**



- Does your child use fluoride products - Rinse, Drops? **Yes No Don't know**
- Has your child had any clicking or pain in the jaw joints? **Yes No Don't know**

If "yes" - Explain: \_\_\_\_\_

- Has your child inherited any family or dental characteristics? **Yes No Don't know**

If "yes" - Explain: \_\_\_\_\_

- Has your child ever injured his/her teeth? **Yes No Don't know**
- Did your child use a pacifier/soother? **Yes No Don't know**
- Did your child suck a finger or thumb? **Yes No Don't know**
- Has your child ever had dental x-rays? **Yes No Don't know**

Date: \_\_\_\_\_

Does your child have any other dental problem(s) we should know about?

\_\_\_\_\_

Child's School: \_\_\_\_\_

Child's Grade in School: \_\_\_\_\_

Do you consider your child to be: (Check one [1])

Advanced in learning \_\_\_\_\_

Progressing normally \_\_\_\_\_

Slow learner \_\_\_\_\_

Will your child be uncooperative? ..... **Yes No Don't know**

If "yes" -Explain: \_\_\_\_\_

\_\_\_\_\_

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

Person completing this form: \_\_\_\_\_

Relationship with patient: \_\_\_\_\_

