

Child Patient Information Form

To be completed by a parent or legal guardian. Anything you are unsure about can be discussed at the appointment.

Child's details

Full name _____
Date of birth _____ School year / school _____

Parent / guardian

Full name _____ Relationship _____
Phone _____ Email _____
Address / city _____

Reason for the visit

- | | |
|---|---|
| ☐ Crowded teeth | ☐ Early loss / late loss of baby teeth |
| ☐ Protruding upper teeth | ☐ Adult tooth not coming through |
| ☐ Lower jaw forward | ☐ Referred by dentist |
| ☐ Crossbite | ☐ Routine check |
| Other _____ | |

General health

Does your child have a condition under regular follow-up? ☐ Yes ☐ No
Asthma or allergic nose problems? ☐ Yes ☐ No
Adenoid / tonsil problems or surgery? ☐ Yes ☐ No
Does your child take medication regularly? ☐ Yes ☐ No
Medications _____
Allergies _____

Habits

Thumb or dummy sucking (now or in the past)? ☐ Yes ☐ No
Sleeps with mouth open or breathes through the mouth? ☐ Yes ☐ No
Snoring during sleep? ☐ Yes ☐ No
Lip biting or tongue thrusting noticed? ☐ Yes ☐ No
Teeth grinding? ☐ Yes ☐ No

Dental history

Any injury to the teeth / broken tooth? ☐ Yes ☐ No
Has your child used a brace or appliance before? ☐ Yes ☐ No
Family history of jaw or teeth alignment problems? ☐ Yes ☐ No
Dental X-rays in the last year? ☐ Yes ☐ No

Last dental check-up (approximate date) _____

The information on this form is used only for examination and treatment planning and is protected under Turkish data protection law (KVKK No. 6698). To be completed by a parent or legal guardian and handed in at the clinic.

Date Parent's signature

This document is for general information; always follow your orthodontist's personal instructions. In a medical emergency in Türkiye, call 112.

