Health / Dental History for Child

PATIENT INFORMATION

Patient's Name:_____ Preferred Name:_____

Sex: ☐ Male ☐ Female Age:_____ Birthdate:_____/_____/_____

Home Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Email:_____

School:_____ Hobbies:_____

Who recommended an orthodontic evaluation:_____

How did you find out about our office:_____

PARENT / GUARDIAN INFORMATION

☐ **Mother** ☐ Stepmother ☐ Guardian Name:_____

Birthdate:_____/_____/_____ SS#:_____

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Spouse Name:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Email:_____

Employer:_____ Occupation:_____ Years There:_____

☐ **Father** ☐ Stepfather ☐ Guardian Name:_____

Birthdate:_____/_____/_____ SS#:_____

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Spouse Name:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Email:_____

Employer:_____ Occupation:_____ Years There:_____

RESPONSIBLE PARTY INFORMATION

☐ Mother ☐ Father ☐ Other Name:_____

Relationship to Patient:_____ Birthdate:_____/_____/_____ SS#:_____

Address:_____

City:_____ State:_____ Zip:_____ Phone:_____

INSURANCE INFORMATION

Insurance Company:_____ Phone:_____

Insured Name:_____ Birthdate:_____/_____/_____ SS#_____

ID#:_____ Group #:_____ Employer:_____

Secondary Insurance Company:_____ Phone:_____

Insured Name:_____ Birthdate:_____/_____/_____ SS#_____

ID#:_____ Group #:_____ Employer:_____

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship to Patient:_____

City:_____ State:_____ Phone:_____ 2nd Phone:_____

Patient Name:_____

DENTAL INFORMATION

Dentist:_____ Phone:_____ Date of Last Visit:_____

Dental History

☐Y ☐N	Pre-Medicate for Dental Treatment
☐Y ☐N	Trauma to Teeth
☐Y ☐N	Trauma to Face/Jaw/Chin
☐Y ☐N	Missing Permanent Teeth
☐Y ☐N	Extra Permanent Teeth
☐Y ☐N	Gum/Periodontal Disease
☐Y ☐N	Gum/Periodontal Treatment
☐Y ☐N	Bad Bite
☐Y ☐N	Jaw Pain
☐Y ☐N	Jaw Popping/Locking
☐Y ☐N	TMJ Treatment
☐Y ☐N	Ringing in Ears
☐Y ☐N	Frequent Cold Sores

Habits

☐Y ☐N	Thumb/Finger Sucking
☐Y ☐N	Grinding/Clenching
☐Y ☐N	Lip/Cheek Biting
☐Y ☐N	Nail Biting
☐Y ☐N	Snoring/Mouth Breathing

Orthodontic History

☐Y ☐N	Previous Orthodontic Evaluation
☐Y ☐N	Previous Orthodontic Treatment

What are the main concerns that you and the patient would like orthodontic treatment to accomplish?

_____

_____

Mostly Concerned with: ☐ Appearance ☐ Quality ☐ Cost ☐ Comfort ☐ Time

MEDICAL INFORMATION

Physicians Name:_____ Phone:_____

Patient's Height:_____ Weight:_____ Father's Height:_____ Mother's Height:_____

Medical History

☐Y ☐N	Recent Increase in Growth
☐Y ☐N	Reached Puberty
☐Y ☐N	Girls - Started Menstruating
☐Y ☐N	Boys - Voice Changed
☐Y ☐N	ADD/ADHD
☐Y ☐N	Arthritis
☐Y ☐N	Artificial Bones/Joints/Valves
☐Y ☐N	Asthma
☐Y ☐N	Blood Disorders
☐Y ☐N	Cancer
☐Y ☐N	Convulsions/Epilepsy
☐Y ☐N	Diabetes
☐Y ☐N	Endocrine/Thyroid Problems
☐Y ☐N	Fainting Spells
☐Y ☐N	Glaucoma
☐Y ☐N	Handicaps/Disabilities
☐Y ☐N	Headaches/Earaches
☐Y ☐N	Hearing Problems
☐Y ☐N	Heart Defects
☐Y ☐N	Heart Surgery
☐Y ☐N	Hepatitis (Type_____)
☐Y ☐N	High/Low Blood Pressure
☐Y ☐N	HIV Positive or AIDS
☐Y ☐N	Kidney/Liver Problems
☐Y ☐N	Psychiatric Treatment
☐Y ☐N	Rheumatic Fever
☐Y ☐N	Serious Illness
☐Y ☐N	Surgery
☐Y ☐N	Tobacco Use
☐Y ☐N	Tonsils/Adenoids Removed
☐Y ☐N	Tuberculosis

Allergies

☐Y ☐N	Latex
☐Y ☐N	Nickel/Metals
☐Y ☐N	Plastic

Drug/Additional Allergies:_____

Current Medications:_____

Women Only:

☐ Pregnant ☐ Nursing ☐ Taking Birth Control

I, understand and have completed the health questionnaire and certify that the preceding information is true and correct. This office will not be held responsible for any problem arising out of inadequate information not disclosed. I grant authority to the Doctor and Staff to perform all procedures and treatments in the patient's best interest. I understand that, where appropriate, a Credit Bureau Report may be obtained.

_____ _____ _____

(Signature Parent/Guardian) (Date) (Orthodontist signature)