about faces and braces ORTHODONTICS

CHILD HISTORY FORMS

Patient Information

NAME: GENDER: DATE:

PARENT SSN: BIRTHDATE: AGE:

STREET ADDRESS: CITY: STATE: ZIP CODE:

PRIMARY PHONE NUMBER: PHONE TYPE: ◯ HOME ◯ CELL OK TO LEAVE MESSAGE?: ◯ YES ◯ NO

EMAIL: SCHOOL: GRADE:

LIST OF ANY SPORTS OR EXTRACURRICULAR ACTIVITIES:

SIBLINGS (NAMES AND AGES)

PARENT/GUARDIAN MARITAL STATUS: SSN:

RELATION TO CHILD: BIRTHDATE: DRIVER'S LICENSE NUMBER:

AT YOUR HOME ADDRESS, DO YOU: ◯ RENT ◯ OWN

HOW LONG HAVE YOU LIVED AT YOUR CURRENT ADDRESS? (REQUIRED)

ADDRESS (IF DIFFERENT THAN CHILDS) CITY: STATE: ZIP CODE:

PRIMARY PHONE NUMBER: PHONE TYPE: ◯ HOME ◯ CELL

SECONDARY PHONE NUMBER: PHONE TYPE: ◯ HOME ◯ CELL

EMPLOYER'S NAME: OCCUPATION:

EMERGENCY CONTACT'S NAME: PHONE NUMBER: RELATION TO PATIENT:

HOW LONG HAVE YOU WORKED AT YOUR CURRENT JOB? (REQUIRED)

Primary Dental Insurance and Dental History (Please do NOT provide medical Insurance)

PRIMARY INSURANCE COMPANY: PHONE NUMBER:

SUBSCRIBER NAME:

SUBSCRIBER NUMBER: POLICY HOLDER'S SSN: POLICY HOLDER'S DATE OF BIRTH:

GENERAL DENTIST: DATE LAST VISIT:

HOW DID YOU HEAR ABOUT OUR PRACTICE:

NAME OF PERSON REFERRING (IF APPLICABLE)

WHAT ARE THE MAIN CONCERNS YOU WOULD LIKE ORTHODONTICS TO CORRECT?

HAS YOUR CHILD VISITED AN ORTHODONTIST BEFORE? ◯ YES ◯ NO

HAS YOUR CHILD'S TONSILS OR ADENOIDS BEEN REMOVED? ◯ YES ◯ NO

HAS YOUR CHILD EVER EXPERIENCED JAW JOINT PAIN/DISCOMFORT (TMJ/TMD)? ◯ YES ◯ NO

DO YOU HAVE ANY MISSING OR EXTRA PERMANENT TEETH? ◯ YES ◯ NO

HAS YOUR CHILD EVER HAD INJURY TO TEETH, MOUTH, OR CHIN? ◯ YES ◯ NO

DOES YOUR CHILD HAVE SPEECH PROBLEMS ◯ YES ◯ NO

DOES YOUR CHILD CURRENTLY OR HAVE YOU EVER HAD ANY OF THE FOLLOWING HABITS (CHECK ALL THAT APPLY)

◯ CLENCHING/GRINDING TEETH ◯ LIP SUCKING/BITING ◯ MOUTH BREATHING

◯ NAIL BITING ◯ THUMB/FINGER SUCKING ◯ CHEWING/EATING PROBLEM

Medical History

IS YOUR CHILD CURRENTLY BEING TREATED BY A PHYSICIAN? ◯ YES ◯ NO

NAME OF PRIMARY CARE PHYSICIAN:

REASON FOR LAST VISIT:

DOES YOUR CHILD HAVE ANY ALLERGIES/SENSITIVITIES TO MEDICATION OR LATEX? IF YES, PLEASE LIST ◯ YES ◯ NO

IS YOUR CHILD CURRENTLY TAKING ANY PRESCRIPTION OR OVER THE COUNTER MEDICATION? IF YES, PLEASE LIST WITH DOSAGE ◯ YES ◯ NO

HAVE YOU EVER HAD BLOOD TRANSFUSION? IF YES, GIVE APPROXIMATE DATES ◯ YES ◯ NO

HAVE YOU HAD ANY SERIOUS ILLNESSES OR OPERATIONS? IF YES, PLEASE DESCRIBE: ◯ YES ◯ NO

CHECK IF YOU HAVE EVER HAD ANY OF THE FOLLOWING:

◯ ANEMIA
◯ ARTHRITIS, RHEUMATISM
◯ ARTIFICIAL HEART VALVES
◯ ARTIFICIAL JOINTS
◯ ASTHMA
◯ BACK PROBLEMS
◯ BLOOD DISEASE
◯ CANCER
◯ CHEMICAL DEPENDENCY
◯ CHEMOTHERAPY
◯ CIRCULATORY PROBLEMS
◯ CORTISONE TREATMENTS
◯ COUGH, PERSISTENT
◯ COUGHING BLOOD
◯ DIABETES
◯ EPILEPSY
◯ FAINTING
◯ GLAUCOMA
◯ HEADACHES
◯ HEART MURMUR
◯ HEART PROBLEMS
◯ HEMOPHILIA
◯ HEPATITIS
◯ HIGH BLOOD PRESSURE
◯ HIV/AIDS
◯ JAW PAIN
◯ KIDNEY DISEASE
◯ LIVER DISEASE
◯ MITRAL VALVE PROLAPSE
◯ PACEMAKER
◯ RADIATION TREATMENT
◯ RESPIRATORY DISEASE
◯ RHEUMATIC FEVER
◯ SCARLET FEVER
◯ SHORTNESS OF BREATH
◯ SKIN RASH
◯ STROKE
◯ THYROID PROBLEMS
◯ TOBACCO HABIT
◯ TONSILLITIS
◯ TUBERCULOSIS
◯ ULCER
◯ VENEREAL DISEASE (STD)

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my medical status. I hereby authorize the release of any information pertaining to my medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance. I understand that where appropriate, credit bureau reports may be obtained.

SIGNATURE:_____ DATE:_____