CHILD PATIENT HISTORY

Patient Information:

Date:_________________

Patient's Last Name _____________________________ First__________________________ Initial_______

Prefers To Be Called_________________________ Hobbies/Activities _______________________________

Birth Date _____/______/________ Sex: □Male □Female SS#__________-___________-___________

School: __________________________ Grade: _________ E-mail address(s)_________________________

Home Address:____________________________ City, State, Zip code:______________________________

Home Phone (______)___________________ Cell Phone (______)__________________

Parent/Guardian Information:

Custodial parent(s) name(s)____

Patient Lives with (CHECK ALL THAT APPLY) □Mother □Father □Stepmother □Stepfather □Grandparent(s)

□Other ____

Father's full name:____ Title □Mr. □Dr. □Other__________

Occupation___________________________________ E-mail Address______________________________

Address (if different) ____

Home Phone (____)_____________ Cell Phone (_____)_____________ Work Phone (_____)______________

SS#__________-___________-___________ Birth Date _______/______/________

Mother's full name:____ Title □Mrs. □Dr. □Other__________

Occupation___________________________________ E-mail Address______________________________

Address (if different) ____

Home Phone (____)_______________ Cell Phone (_____)_____________ Work Phone (_____)____________

SS#__________-___________-___________ Birth Date _______/______/________

Responsible Party:

Name ____

Address (if different):____________________________ City, State, Zip code:__________________________

Home Phone (if different): (_______)___________________ Cell Phone (_______)________________________

Who is responsible for bringing patient to orthodontic appointments?_________________________________

General Information:

Whom may we thank for referring you?____

Brother/Sister name_____________________________ age _________ had orthodontic treatment? □YES □NO

Brother/Sister name_____________________________ age _________ had orthodontic treatment? □YES □NO

If yes, where were they treated?____

Emergency Information: Outside of immediate Family/Household

Name ____ Phone (______)____________________
Address:_____________________________ City, State, Zip code:_____________________________________

Insurance Information:

Primary Orthodontic Insurance	**Secondary Orthodontic Insurance**
Do you have Orthodontic Coverage? □YES □NO	**Do you have Orthodontic Coverage? □YES □NO**
Insurance Co. Name: ________________________________	Insurance Co. Name: ________________________________
Insurance Co. Address:________________________________	Insurance Co. Address:________________________________
Insurance Co. Phone Number:__________________________	Insurance Co. Phone Number:__________________________
Group# (Plan, Local or Policy#):_____________________________	Group# (Plan, Local or Policy#):_____________________________
Insured's Name:______________________________________	Insured's Name:______________________________________
Relationship to Patient:______________________________	Relationship to Patient:______________________________
Insured's Birth Date: ________/_________/__________	Insured's Birth Date: ________/_________/__________
Insured's ID#(SS#)____________________________________	Insured's ID#(SS#)____________________________________
Insured's Employer:___________________________________	Insured's Employer:___________________________________

Dentist:

Patient's Dentist: ____ Phone (______)___________________
Address:________________________________ City, State, Zip code:____
Last Seen _______________________ Reason ____
When was his/her last cleaning? ____
Other dentists/ dental Specialists now being seen:____
Reason____

Dental History:

What are your main concerns that you would like orthodontics to accomplish?_________________________________

____

Have he/she ever been evaluated for orthodontic treatment? □YES □NO

Now or in the past, has the patient had:

Jaw fractures, cyst, infections?	□YES □NO
History of speech problems or speech therapy?	□YES □NO
History of speech problems?	□YES □NO
Frequent oral habits (sucking finger, chewing pen, etc)	□YES □NO
Teeth causing irritation to lip, cheek, or gums?	□YES □NO
Has your child been treated for "TMJ" or "TMD"	□YES □NO
Any serious trouble associated with previous treatment	□YES □NO
Has your child ever been diagnosed with gum disease or pyorrhea	□YES □NO

Medical History:

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Is your child under a physician's care now? □YES □NO

Has your child ever been hospitalized or had an operation? □YES □NO

Has your child ever had a serious injury to his/her head or neck? □YES □NO

Is your child taking any medication, pills, or drugs?(Include illegal/recreational drugs) □YES □NO

Please explain if you have answered YES to any of the above questions. ____________________________________

____

Is your child allergic to any medications or substances? (Please check box for allergic reaction below) □YES □NO

□Aspirin □Penicillin □Acrylic □Metal □Latex Rubber □Local Anesthetics □Foods__________________________

□Other ____

Medication ____ Taken for ______________________________________

Does the patient have or has he/she ever had any of the following:

Heart Trouble/Disease	□YES □NO	Leukemia	□YES □NO	Frequent Diarrhea	□YES □NO
Heart Murmur	□YES □NO	Recent Blood Transfusion	□YES □NO	Excessive Thirst	□YES □NO
Irregular Heart Beat	□YES □NO	Swelling of Limbs	□YES □NO	Hypoglycemia	□YES □NO
Angina/Chest Pain	□YES □NO	Lung Disease	□YES □NO	Stroke	□YES □NO
Congenital Heart Disorder	□YES □NO	Breathing Problems	□YES □NO	Hepatitis, Jaundice or Liver Disease	□YES □NO
Mitral Valve Prolapse	□YES □NO	Shortness of Breath	□YES □NO	Kidney Problems	□YES □NO
Scarlet Fever	□YES □NO	Frequent Cough	□YES □NO	Renal Dialysis	□YES □NO
Rheumatic Fever	□YES □NO	Hay Fever	□YES □NO	Parathyroid Disease	□YES □NO
Artificial Heart Valve	□YES □NO	Sinus Trouble	□YES □NO	Arthritis/Gout	□YES □NO
Heart Pace Maker	□YES □NO	Asthma	□YES □NO	Rheumatism	□YES □NO
Heart Surgery	□YES □NO	Fever Blisters	□YES □NO	Pain in Jaw Joints	□YES □NO
High Blood Pressure	□YES □NO	ADD/DHD	□YES □NO	Cortisone Medicine	□YES □NO
Low Blood Pressure	□YES □NO	Emphysema	□YES □NO	Artificial Joints	□YES □NO
Blood Disease	□YES □NO	Tuberculosis	□YES □NO	AIDS/ HIV Positive	□YES □NO
Alcohol Use/Abuse	□YES □NO	Cancer	□YES □NO	Herpes (Cold Sore)	□YES □NO
Depression	□YES □NO	Radiation Therapy	□YES □NO	Sexually Transmitted Disease	□YES □NO
Bruise Easily	□YES □NO	Chemotherapy	□YES □NO	Drug Addiction/Use	□YES □NO
Anemia	□YES □NO	Stomach/Intestinal Disease	□YES □NO	Snoring/Sleep Apnea	□YES □NO
Excessive Bleeding	□YES □NO	Ulcers	□YES □NO	Vision or Hearing Problem	□YES □NO
Sickle Cell Disease	□YES □NO	Recent Weight Loss	□YES □NO		
Hemophilia	□YES □NO				

Have you ever had any other serious illness not checked above? Describe:_________________________________

____

Has your child ever taken IV or Oral bisphosphonates for bone disorder? □YES □NO

To the best of your knowledge, all the preceding answers are correct. If my child has any changes in his/her health status or if his/her medication changes, I shall inform the dentist and staff at the next appointment without fail I will inform the doctor promptly of any medications legal or illegal, prescription or non-prescription that he/she is taking. In Accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), a NOTICE that describes how medical information about your child may be used and disclosed and how you can get access to this information is available upon request. Should I desire to have a copy of this NOTICE, I will check the following box and notify the RECEPTIOINST:

□ I DO WANT A COPY OF 'NOTICE' □ I DO NOT WANT A COPY OF 'NOTICE'

Signature: ____ Date:____________________

□Father □Mother □Guardian

Reviewed by Doctor:____ Date: _______________

History review and significant findings:____

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Medical History Update

Date	Comments	Signature
____________	____	______________
____________	____	______________
____________	____	______________
____________	____	______________
____________	____	______________
____________	____	______________
____________	____	______________
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