Child Health History Form

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1. Tell Us About Your Child

Today's Date: _____ ☐ Female ☐ Male

Child's Name: _____ _____ _____
LAST FIRST MI

Nickname: _____ Home #: (___)_____

Birthdate: _____ Age: _____

School: _____ Grade: _____

Hobbies / Sports: _____

Home Address: _____
APT /CONDO#

_____ _____ _____
CITY STATE ZIP

2. Who Is Accompanying Your Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐Yes ☐No

Whom may we thank for referring you? _____

List siblings with ages: _____

_____

General Dentist: _____

Last Visit Date: _____

Parent's Marital Status: ☐ Single ☐Widowed
☐ Married ☐ Divorced ☐Separated

3. Parent Information

Mother's Information: ☐Step Mother ☐Guardian

Name: _____

Birthdate: _____ Cell#: (_____)_____

Employer: _____

Job Title: _____ How Long? _____

SS #: _____ DL #: _____

Father's Information: ☐Step Father ☐Guardian

Name: _____

Birthdate: _____ Cell#: (_____)_____

Employer: _____

Job Title: _____ How Long? _____

SS #: _____ DL #: _____

4. Person Responsible for Account

Name: _____ Relation: _____

Home Address: _____
APT /CONDO#

_____ _____ _____
CITY STATE ZIP

Cell#: (_____)_____ Home#: (_____)_____

Email Address: _____ Employer: _____

SS #: _____ DL #: _____

Who is responsible for making appointments?

Name: _____

Work #: (_____)_____ Ext.: _____

Home #:(_____)_____

5. Primary Orthodontic Insurance

Primary Orthodontic Coverage

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone#: _____

Group# (Plan, Local, or Policy#): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate:_____ SS #: _____

Policy Owner's Employer: _____

Secondary Orthodontic Coverage

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone#: _____

Group# (Plan, Local, or Policy#): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate:_____ SS #: _____

Policy Owner's Employer: _____

6. What are the main concerns that you would like orthodontic treatment to address?

_____

_____

_____

_____

Has your child ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

Have there been any injuries to the face, mouth, teeth, or chin? ☐ Yes ☐ No

List any musical instruments played: _____

_____

Have your child's adenoids or tonsils been removed? ☐ Yes ☐ No

Has your child been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Has your child ever had any pain / tenderness in their jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Does your child brush their teeth daily? ☐ Yes ☐ No

Does your child floss their teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone #: (___)_____ Date of last visit: _____

Is your child currently under the care of a physician? ☐ Yes ☐ No

Has puberty begun? ☐ Yes ☐ No

Has menstruation begun? (Girls) ☐ Yes ☐ No

Please describe your child's current physical health: ☐ Good ☐ Fair ☐ Poor

Please list all drugs that your child is currently taking:

_____

Please list all drugs/ things that your child is allergic to:

_____

7. Has your child ever had any of the following medical conditions?

☐Abnormal Bleeding
☐Allergies to any Drugs
☐Handicaps/Disabilities
☐Hearing Impairment
☐Allergic to Latex/Metals
☐Any Operations
☐Kidney/Liver Problems
☐Rheumatic/Scarlet Fever
☐Congenital Heart Defect
☐Convulsions/Epilepsy
☐Diabetes
☐Allergic to Plastic
☐Heart Murmur
☐Any Hospital Stays
☐Hemophilia
☐Hepatitis
☐Asthma
☐HIV+/AIDS
☐Tuberculosis (TB)
☐Cancer

8. Does/did your child have any of the following habits?

☐Clenching/Grinding Teeth
☐Nursing Bottle Habits
☐Thumb/Finger Sucking
☐Nail Biting
☐Lip Sucking/Biting
☐Speech Problems
☐Mouth Breather
☐Tongue Thrust

9. Parent's Authorization

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services my child may need.

_____
Signature of parent or guardian

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

_____
Signature of parent or guardian

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

_____
Signature of parent or guardian

Office Use Only

I verbally reviewed the medical information with the parent/guardian and patient named herein.

Doctor's Comments: _____

_____

_____

_____

Initials: _____ Date: _____