

Child New Patient Health History

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

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 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 his/her jaw joint (TMJ/TMD)? yes no

Does your child brush his/her teeth daily? yes no

Floss his/her 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: _____

Please list all drugs that your child is currently taking: _____

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

Y N Latex Y N Metals/Nickel

Y N Plastics

Has your child ever had any of the following medical problems?

Y N Abnormal Bleeding

Y N Convulsions/Epilepsy

Y N ADD/ADHD

Y N Diabetes

Y N Allergies to any Drugs

Y N Handicaps/Disabilities

Y N Allergic to Latex/Metals

Y N Hearing Impairment

Y N Allergic to Plastic

Y N Heart Murmur

Y N Any Hospital Stays

Y N Hemophilia

Y N Any Operations

Y N Hepatitis

Y N Artificial Bones/Joints/Valves

Y N HIV+/AIDS

Y N Asthma

Y N Lupus

Y N Cancer

Y N Rheumatic/Scarlet Fever

Y N Congenital Heart Defect

Y N Tuberculosis (TB)

Please discuss any medical problems that your child has had: _____

Has your child ever experienced any of the following?

Y N Clenching/Grinding Teeth

Y N Nursing Bottle Habits

Y N Lip Sucking/Biting

Y N Speech Problems

Y N Mouth Breather

Y N Thumb/Finger Sucking

Y N Nail Biting

Y N Tongue Thrust

Neighbor or Relative not living with you.

Name _____ Phone (____)_____

Address _____

City

State

ZIP

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 my need.

Signature

Date

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.

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. I hereby authorize payment of the group insurance benefits directly to this office.

Signature

Date

Signature

Date

The Parent or Guardian who accompanies the child is responsible for payment.

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, and the CDC and the ADA.