



CHILD HEALTH HISTORY FORM

Date: _____

PATIENT INFORMATION

Child's Name _____ Child's DOB _____ Age _____
Last First Middle

Name Child prefers to be called _____

Child's Home Address _____ City _____ State _____ Zip _____

Child's Home Phone Number _____

Child's School Name _____ Grade _____

Parent's E-mail (used for appointment reminders, kept confidential) _____

Sports/Hobbies _____ Musical Instrument Played _____

Names and Ages of Other Family Members _____

Names of Other Family Members Treated in this Office _____

Who may we thank for referring you to our Office? _____

Who is accompanying this child today? _____

Your Name _____ Your relationship to Child _____

(Natural Parent Yes No) (Child Adopted Yes No) (Foster Parent Yes No) Other-Specify _____

PARENT INFORMATION

MOTHER

Mother's Marital Status _____ Married _____ Divorced _____ Widow _____ Single _____ Remarried _____

Choose: Mother _____ Stepmother _____ Guardian _____

Name _____ Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Employer _____

Cell Phone _____ Email Address _____

SS# _____ DOB _____

FATHER

Father's Marital Status _____ Married _____ Divorced _____ Widow _____ Single _____ Remarried _____

Choose: Father _____ Stepfather _____ Guardian _____

Name _____ Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Employer _____

Cell Phone _____ Email Address _____

SS# _____ DOB _____

PERSON RESPONSIBLE FOR THIS ACCOUNT

Name _____ Address _____ City _____ State _____ Zip _____

SS# _____ Daytime Phone _____ Evening Phone _____

DOB _____

INSURANCE INFORMATION

Primary Insurance Information

Relationship to Patient _____

Insured's Name _____ Insured's DOB _____ Insured SS# _____

Employer's Name _____ Employer's Ph # _____

Employer's Address _____ City _____ State _____ Zip _____

Insurance Company _____ City _____ State _____ Zip _____

Insurance Ph # _____ Name of Dental Plan _____

Insurance ID # _____

Secondary Insurance Information

Relationship to Patient _____

Insured's Name _____ Insured's DOB _____ Insured SS# _____

Employer's Name _____ Employer's Ph # _____

Employer's Address _____ City _____ State _____ Zip _____

Insurance Company _____ City _____ State _____ Zip _____

Insurance Ph # _____ Name of Dental Plan _____

Insurance ID # _____

Reviewed with patient by _____ Date _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Physician's Address _____ City _____ State _____ Zip _____

Please Circle Yes or No (If Yes, please fill in the details)

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Are you presently under care of a physician _____ Do you have a history of a major illness? _____
Yes No Have you ever had any major operation? _____ Yes No Ever been hospitalized? _____
Yes No Have you had your tonsils or adenoids removed? _____
Yes No Have you had any of the following: Asthma _____ Allergies _____ Hay Fever _____ Throat Infections _____
Yes No Are you allergic to anything? If yes please describe _____

Please circle the appropriate answer for the medical conditions below:

Yes No Abnormal Bleeding Yes No Endocrine Problems Yes No Liver Disease
Yes No Tuberculosis Yes No Anemia Yes No Epilepsy
Yes No Lung/Respiratory Yes No AIDS Yes No Arthritis
Yes No Glaucoma Yes No HIV+ Yes No Blood Disorder
Yes No Heart Murmur Yes No Nervous Disorders Yes No Contact Lenses
Yes No Bone/Joint Disorders Yes No Heart Problems Yes No Pneumonia
Yes No Cancer/Tumor Yes No Hepatitis -Type _____ Yes No Prolonged Bleeding
Yes No Diabetes Yes No Herpes Yes No Hyperactive
Yes No High Blood Pressure Yes No Rheumatic Heart Yes No Thyroid Disease
Yes No Dizziness/Fainting Yes No Emotional Problems Yes No Sinusitis
Yes No Kidney Involvement Yes No Other _____

DENTAL HISTORY

Dentist _____ Date of Last Visit _____
Dentist's Address _____ City _____ State _____ Zip _____ Phone # _____

What concerns you most about your teeth? _____
Does the patient want teeth straightened? _____

Please circle the appropriate answer to the following questions, and explain if needed:

Yes No Have there ever been any injuries to the face, mouth or teeth? _____
Yes No Have you ever been informed of missing, extra or chipped teeth? _____
Yes No Have you ever had any abscessed teeth? _____
Yes No Is any of your mouth sensitive to temperature or pressure? _____
Yes No Do your gums bleed when you brush your teeth? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Have you ever had any speech therapy? _____
Yes No Do you have TMJ? _____
Yes No Are you aware of your jaw clicking or popping? _____
Yes No Have you ever been told that you grind your teeth? _____
Yes No Are you aware of clenching your teeth? _____
Yes No Do you have "tension" headaches? _____
Yes No Do you have "frequent" headaches? _____
Yes No Do you brush your teeth daily? How many times? _____
Yes No Do you floss your teeth daily? _____

BENEFITS OF ORTHODONTICS

Aesthetics, Health and Function

Orthodontics is a service that provides an improvement in the appearance of the teeth and in the general function of the teeth, and general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout lifetime, and there can be some movement of the teeth, and some change after treatment. I hereby state that I have read and understand the above paragraph, and that I have truthfully to the best of my ability answered all the above questions.

Patient/Parent Signature _____ Date _____

OFFICE USE

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein. Initials: _____ Date _____

Doctor's comments:
