elite ORTHODONTICS

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 #_____

CONTINUED ON OPPOSITE SIDE

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 th e details)

Yes No Are you taking any medication?_____
Yes No Are you allergic to any medication?_____
Yes No Are you prese ntly 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 allerg ic 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/Tumo r	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:

_____

_____

SUBMIT