WELCOME TO DR. Patel's Orthodontic Office

Child's Health History

Today's Date_____ Nick Name:_____
Patient's Name:_____
Patient's Birthday__/__/__ Age___ M F
School:_____ Grade:_____
Hobbies:_____
Patient's Home# (____)_____
Patient's Home Address:_____
_____
City_____ Zip_____

Who is accompanying the patient today?
Name:_____ Relation:_____
Do you have legal custody of the patient? Y N
Referred by:_____
Brothers or sisters:_____
General Dentist:_____ Last visit:_____
Dentist's Phone #_____
Relative or Friend not living with you:
Name:_____ Phone:_____

Who is responsible for account?_____ Parent's Marital Status []Single[]Maried[]Partnered[] Widowed[] Divorced[]Separated

[]Father []Step Father []Guardian
Name:_____ DOB___/___/___
Address:(If different than Patient)
_____
_____
SS#:_____-_____-_____ DL#_____
WK#(___)_____Ext:_____Hm#:(___)_____
Employer:_____Cell#:(___)_____
Occupation:_____ How long there?_____
Employer's Address:_____
City_____State_____Zip_____

[]Mother []Step Mother []Guardian
Name:_____DOE___/___/___
Address:(if different than Patient)
_____
_____
SS#:_____-_____-_____ DL#_____
WK#(___)_____Ext:_____Hm#:(___)_____
Employer:_____Cell#:(___)_____
Occupation:_____ How long there?_____
Employer's Address:_____
City_____State_____Zip_____

If you have Orthodontic Insurance Coverage please fill out:
Insurance Co. Name:_____
Insurance Address:_____
City_____State_____Zip_____
Insurance Phone:(____)_____
Group#(Plan, Local, or Policy#):_____

If you have Orthodontic Insurance Coverage please fill out:
Insurance Co. Name:_____
Insurance Address:_____
City_____State_____Zip_____
Insurance Phone:(____)_____
Group#(Plan, Local, or Policy#):_____

Authorization

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 Dr. Patel's office accepts the insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover. I hereby authorize the dentist to release all information necessary to to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions. Whether manual or electronic.

Signature of Parent or Guardian_____Date_____

Dental & Medical History

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

_____

_____

Has your child ever been evaluated or had orthodontic treatment before? Y N

Have there been any injuries to the face, mouth or chin? Y N

Does the child require antibiotics before dental treatment? Y N

Have adenoids or tonsils been removed? Y N

Does your child have any missing or extra permanent teeth? Y N

Has the child ever had any pain/ tenderness in his/her jaw joint (TMJ/TMD) Y N

Does the child brush his/her teeth daily? Y N

Floss his/her teeth daily? Y N

Child's Physician: _____

Phone #:_____ Date of Last Visit: _____

Is the child currently under the care of a physician? Y N

Has puberty begun? Y N

Has menstruation begun? Y N

Please describe the child's current physical health:

☐ Good ☐ Fair ☐ Poor

Pleas list all drugs that the child is currently taking:

_____

_____

Aside from items listed below, list all drugs/things your child is allergic to:

_____

_____

Y N Latex/ Metals Y N Nickle Y N Plastic

Has your child experienced the following medical problems?

Y N	Abnormal Bleeding	Y N	Hearing Impairment
Y N	ADD/AHD	Y N	Heart Murmur
Y N	AIDS/ HIV+	Y N	Hemophilia
Y N	Any Hospital Stays/Operations	Y N	Hepatitis
Y N	Artificial Bones/Joints/Valves	Y N	Kidney Problems
Y N	Asthma	Y N	Liver Problems
Y N	Cancer	Y N	Mitral Valve Prolapse
Y N	Congentital Heart defect	Y N	Prosthetics
Y N	Convulsions	Y N	Pheumatic Fever
Y N	Diabetes	Y N	Scarlet Fever
Y N	Epilepsy	Y N	Sickle Cell Disease/Traits
Y N	Handicaps/ Disabilities	Y N	Tuberculosis (TB)

Has the child ever taken any diet pills such as Phen-Fen? Y N

(Also known as Redux or Pondimin.) If so, when? _____

Are the child's immunizations current? Y N

Anything you would like to discuss with the Doctor in private? Y N

Please discuss any serious medical problems the child has had:

_____

_____

_____

Does/did the child have any of the following habits?

Y N	Breast Fed	Y N	Nursing Bottle Habits
Y N	Clenching/ Grinding Teeth	Y N	Speech Problems
Y N	Lip Sucking/ Biting	Y N	Thumb/ Finger Sucking
Y N	Mouth Breather	Y N	Tongue Thrust
Y N	Nail Biting	Y N	Used Pacifier

List any musical instruments played:_____

_____

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

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my reponsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental/ orthodontic services my child may need.

_____

Signature of Parent or Guardian Date

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I have verbally reviewed the medical/ dental information above with the parent/ guardian & patient named herein.

_____

Signature of Dentist Date

Dentist's Comments:_____

_____

Medical History Update

Has there been any change in your child's health status since their last visit? Y N

If Yes, please explain._____

_____

_____

Parent/ Guardian Signature Date

_____

Dentist Signature Date