

## Dental & Health History

## CONFIDENTIAL

How often does the child brush? \_\_\_\_\_

Is your child's water fluoridated?..... ☐ Yes ☐ No

Does your child:

Suck thumb/finger..... ☐ Yes ☐ No

Suck/Bite lip..... ☐ Yes ☐ No

Bite/Chew nails..... ☐ Yes ☐ No

Chew hard objects (pencils, etc.)..... ☐ Yes ☐ No

Dentist \_\_\_\_\_

Date of last dental visit? \_\_\_\_\_

Has the child had difficulty with previous dental visits? \_\_\_\_\_

Child's physician \_\_\_\_\_

Date of last exam? \_\_\_\_\_

How often does your child floss? \_\_\_\_\_

Does the child take fluoride supplements?..... ☐ Yes ☐ No

Grind teeth..... ☐ Yes ☐ No

Clench jaws..... ☐ Yes ☐ No

Gag easily..... ☐ Yes ☐ No

Tonsils/Adenoids removed \_\_\_\_\_ age..... ☐ Yes ☐ No

Speech Problem..... ☐ Yes ☐ No

Address \_\_\_\_\_

Phone # \_\_\_\_\_

☐ Yes ☐ No

Address \_\_\_\_\_

Phone # \_\_\_\_\_

Previous Hospitalizations/Surgeries/Serious Illnesses? \_\_\_\_\_

When? \_\_\_\_\_

Have you been informed of any missing or extra teeth? ☐ Yes ☐ No

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

Is the child a mouth breather? while awake \_\_\_\_\_ while asleep \_\_\_\_\_ ☐ Yes ☐ No

Has the child ever had any pain/tenderness in their jaw (TMJ/TDM) ☐ Yes ☐ No (explain) \_\_\_\_\_

Has the child reached puberty? ☐ Yes ☐ No

**Girl** - started menstruation? ☐ Yes ☐ No **Boy** - has his voice changed? ☐ Yes ☐ No

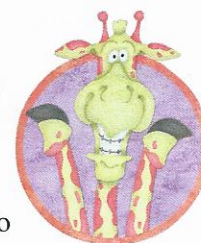
Why did you bring the child to the orthodontist today? \_\_\_\_\_

Is your child currently taking medications? ☐ Yes ☐ No (if yes, please list) \_\_\_\_\_

Has your child ever taken FenPhen/Redux? ☐ Yes ☐ No

Does the child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (penicillin, Novocain, etc.)? ☐ Yes ☐ No (if yes please describe) \_\_\_\_\_

Does the child have a history of allergies to any other substances (latex, environmental, etc.)? ☐ Yes ☐ No



Has the child ever had any of the following:

Asthma..... ☐ Yes ☐ No

Cancer..... ☐ Yes ☐ No

Hepatitis..... ☐ Yes ☐ No

HIV/AIDS..... ☐ Yes ☐ No

Hemophilia..... ☐ Yes ☐ No

A persistent cough or throat clearing  
not associated with a known illness

(lasting more than 3 weeks)..... ☐ Yes ☐ No

Abnormal Bleeding..... ☐ Yes ☐ No

Acid Reflux..... ☐ Yes ☐ No

Stomach, liver or kidney problems..... ☐ Yes ☐ No

Handicaps/Disabilities..... ☐ Yes ☐ No

Tuberculosis..... ☐ Yes ☐ No

Diabetes..... ☐ Yes ☐ No

Rheumatic Fever..... ☐ Yes ☐ No

Congenital Heart Defect..... ☐ Yes ☐ No

Heart Murmur..... ☐ Yes ☐ No

Convulsions/Epilepsy..... ☐ Yes ☐ No

Osteoporosis..... ☐ Yes ☐ No

Hearing Impairment..... ☐ Yes ☐ No

Handicap/Disabilities..... ☐ Yes ☐ No

Please explain any medical problem that your child has: \_\_\_\_\_

## Authorization & Release

I understand that providing incorrect information can be dangerous and it is my responsibility to inform the office of any changes in the child's medical status. I also authorize the staff to perform the necessary services the child may need.

I also authorize the release of any information including the diagnosis and the records of treatment or examination rendered, to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (or parent/guardian if minor) \_\_\_\_\_

Date \_\_\_\_\_





# WELCOME



## ***Your Child***

Child's Name \_\_\_\_\_ Name \_\_\_\_\_  
Nickname \_\_\_\_\_ Sex \_\_\_\_\_ Relationship \_\_\_\_\_  
Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Address \_\_\_\_\_  
SS# / SIN \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_ Email \_\_\_\_\_  
Child's Home Address \_\_\_\_\_ Phone \_\_\_\_\_ SS#/SIN \_\_\_\_\_  
City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_ DL# \_\_\_\_\_  
Phone \_\_\_\_\_

## ***Responsible Party***

## ***Who is responsible for making appointments?***

Name \_\_\_\_\_ Best time to call \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Time \_\_\_\_\_ Day \_\_\_\_\_  
Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

### ***Mother***

☐ Stepmother ☐ Guardian

Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_  
Email \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
SS#/SIN \_\_\_\_\_ D.O.B. \_\_\_\_\_  
DL # \_\_\_\_\_

### ***Father***

☐ Stepfather ☐ Guardian

Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_  
Email \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
SS#/SIN \_\_\_\_\_ D.O.B. \_\_\_\_\_  
DL # \_\_\_\_\_

***Marital Status*** ☐ Single ☐ Married ☐ Divorced  
☐ Widowed ☐ Separated

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## ***Primary Insurance***

Insured's Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_  
Employer \_\_\_\_\_ Date Employed \_\_\_\_\_  
Occupation \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Group # \_\_\_\_\_ Employee # \_\_\_\_\_  
Ins. Co. address \_\_\_\_\_ State/Zip/ \_\_\_\_\_  
City \_\_\_\_\_ Prov. \_\_\_\_\_ P.C. \_\_\_\_\_

## ***Additional Insurance***

Insured's Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_  
Employer \_\_\_\_\_ Date Employed \_\_\_\_\_  
Occupation \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Group # \_\_\_\_\_ Employee # \_\_\_\_\_  
Ins. Co. address \_\_\_\_\_ State/Zip/ \_\_\_\_\_  
City \_\_\_\_\_ Prov. \_\_\_\_\_ P.C. \_\_\_\_\_

## ***Financial Arrangements***

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment. ☐ Cash ☐ Personal Check ☐ Credit Card ☐ Visa ☐ MC ☐ Discover ☐ AMEX  
☐ I wish to discuss the office's payment policy.