DOSWELL ORTHODONTICS

CHILD HEALTH FORM

Child's Information

First Name : Last Name :

Nickname : Birth date : Age :

Gender : M F School : Grade :

Hobbies :

Siblings & Ages :

Other Family Members Seen By Us :

Parent/Guardian Information

First Name : Last Name :

Preferred Name : Title : Mr. Mrs. Ms. Dr. SSN :

Gender : M F Birth Date : Relationship to Patient :

Address :

City : State : Zip :

Cell # : Home # : Work # :

Email :

Employer : Occupation :

Marital Status : Married Single Divorced Widowed If Married, Spouse's Name :

Emergency Contact Information

First Name : Last Name :

Relationship to Patient : Phone # :

Dental Insurance Information

Policy Holder Name : Relationship to Patient :

Policy Holder Employer : Insurance Company Name :

Insurance Phone # : Subscriber ID/SSN : Group Number :

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Child's Medical History

Physician : _____ Physician Phone # : _____ Date of Last Visit : _____

Please list any medications your child is taking: _____

Allergies or reactions to : ☐ Metal or Nickel ☐ Latex ☐ Aspirin, Ibuprofen, Tylenol ☐ Penicillin or other antibiotics ☐ Local anesthetic ☐ Other: _____

Has your child experienced or been treated for any of the following?

Y	N		Y	N		Y	N	
☐	☐	ADD/ADHD	☐	☐	Gastrointestinal Issues	☐	☐	Osteopenia/Osteoporosis
☐	☐	Anemia	☐	☐	Heart Problems	☐	☐	Radiation/Chemotherapy
☐	☐	Arthritis	☐	☐	Hepatitis/Liver Problems	☐	☐	Respiratory Problems
☐	☐	Asthma	☐	☐	Herpes/Fever Blisters	☐	☐	Rheumatic Fever
☐	☐	Blood Conditions	☐	☐	High or Low Blood Pressure	☐	☐	Seizures
☐	☐	Bone Disorder	☐	☐	History of Anorexia or Bulimia	☐	☐	Sinus Problems
☐	☐	Cancer	☐	☐	HIV/AIDS	☐	☐	Stroke
☐	☐	Diabetes	☐	☐	Kidney Problems	☐	☐	Thyroid Problems
☐	☐	Endocrine Disorder	☐	☐	Migraines	☐	☐	Tuberculosis (TB)

Are there any other medical conditions not indicated above that we should be aware of?

_____

Has your child ever taken IV or oral bisphosphonates? ☐ Yes ☐ No Females only: has your daughter begun menstruation? ☐ Yes ☐ No If so, what age? _____

Child's Dental History

Dentist : _____ Dentist Phone # : _____ Date of Last Cleaning : _____

History of trauma to the teeth, face, or jaws? ☐ Yes ☐ No Does your child complain of jaw pain? ☐ Yes ☐ No History of speech problems? ☐ Yes ☐ No

Family history of jaw surgery, underbite, missing teeth, etc.? ☐ Yes ☐ No Habits such as thumb/finger sucking, tongue thrust, nail biting? ☐ Yes ☐ No

Child's Orthodontic History

Has your child ever had orthodontic treatment? If so, when and what? ☐ Yes ☐ No

_____

Has your child had an orthodontic consultation before? ☐ Yes ☐ No

What is your chief concern and/or your child's chief concern about his/her bite, teeth, or smile?

_____

Who can we thank for referring you to our office? _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my child's medical or dental health. I authorize release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company. I also understand that I am responsible for payment for all costs of orthodontic treatment that are not covered by my insurance and agree to make payment at the time it is due.

Signature _____ TC Initials _____ Doctor Initials _____