Date ____________________

Child Health History Form

PATIENT INFORMATION

Patient's last name ____________________ First name ____________________ Middle initial ________

Prefers to be called ____________________ Birth date ________________ Age ________ ❒ Male ❒ Female

Home address ____

City, State, Zip code ____

School ____________________ Grade ________ Other family members seen by us? ____________________

General Dentist ____________________ Date of last dental visit ________________ Physician ________________

How did you hear about our office? ❒ Insurance ❒ Dentist ❒ Patient ____________________ ❒ other ________________

PARENT/ GUARDIAN

Custodial parent(s) name(s) ____

Patient lives with (check all that apply) ❒ Mother ❒ Father ❒ Stepmother ❒ Stepfather ❒ Grandparent(s) ❒ Other ____________

RESPONSIBLE PARTY

The parent or guardian who accompanies the child today is responsible for payment. A copy of your driver's license is required at the initial visit and at treatment start for the parent or guardian accompanying the minor patient (if different than initial visit).

❒ Mr ❒ Dr Father's full name ____ Birth date ________________

Relationship to patient: ❒ Father ❒ Step-Father ❒ Grandparent ❒ Other____________________ Marital Status ______

Address (if different) ____ Social Security # ________________

How long at this address__________ ❒ Own ❒ Rent Home phone ( ) ____________ Mobile phone ( ) ____________

Employer ____________________ Occupation____________________ # Years employed ______

Work phone ( ) ____________ Email address(s) ____

❒ Ms ❒ Mrs ❒ Dr Mother's full name ____ Birth date ________________

Relationship to patient: ❒ Mother ❒ Step-Mother ❒ Grandparent ❒ Other____________________ Marital Status ______

Address (if different) ____ Social Security # ________________

How long at this address__________ ❒ Own ❒ Rent Home phone ( ) ____________ Mobile phone ( ) ____________

Employer ____________________ Occupation____________________ # Years employed ______

Work phone ( ) ____________ Email address(s) ____

DENTAL INSURANCE - **Please bring your insurance card to the first appointment**

PRIMARY policy holder's full name ________________________________ Birth date ________________

SSN or Member ID ________________ Relationship to Patient ________________ Policy holder's employer ________________

Home Address (if different) ________________________________ Group # ________________

Insurance Company ____________________ Address ________________ Insurance phone # ( )____________

SECONDARY policy holder's full name ________________________________ Birth date ________________

SSN or Member ID ________________ Relationship to Patient ________________ Policy holder's employer ________________

Home Address (if different) ________________________________ Group # ________________

Insurance Company ____________________ Address ________________ Insurance phone # ( )____________

I hereby authorize White Orthodontics to submit a claim on behalf of the aforementioned patient. I authorize my insurance company to pay the dental benefits to Richard J. White, D.D.S., L.L.C. I authorize the release of any information relating to this claim.

____ ____________________

Signature Date

Please complete back side of form

MEDICAL HISTORY

Is patient in good health? ❒ Yes ❒ No HEIGHT: _______ WEIGHT: _______

Does patient have any history of major illness? ❒ Yes ❒ No Please explain: ____________________

Has the patient been treated for the following:

❒ Yes ❒ No Asthma
❒ Yes ❒ No Anemia
❒ Yes ❒ No Autism
❒ Yes ❒ No Bone Disorders
❒ Yes ❒ No Cancer, tumor, radiation or chemotherapy
❒ Yes ❒ No Diabetes
❒ Yes ❒ No Endocrine Problems
❒ Yes ❒ No Epilepsy
❒ Yes ❒ No Heart defects, heart murmur, rheumatic heart disease
❒ Yes ❒ No Fainting or Dizziness
❒ Yes ❒ No Hepatitis, jaundice, or other liver problems
❒ Yes ❒ No AIDS or HIV positive
❒ Yes ❒ No Kidney Involvement
❒ Yes ❒ No Nervous Disorders
❒ Yes ❒ No Pneumonia
❒ Yes ❒ No Prolonged Bleeding
❒ Yes ❒ No Rheumatic Fever
❒ Yes ❒ No Tuberculosis
❒ Yes ❒ No Other ______________________________

❒ Yes ❒ No Do you take antibiotic pre-medication before any dental procedures?

❒ Yes ❒ No Have Tonsils and Adenoids been removed?
❒ Yes ❒ No Have you been diagnosed with Obstructive Sleep Apnea?
❒ Yes ❒ No Have you been told you snore excessively?
❒ Yes ❒ No Do you feel like you often wake gasping for air?

Have you had allergies or reactions to any of the following?

❒ Yes ❒ No Latex (gloves, balloons)
❒ Yes ❒ No Metals (jewelry, clothing snaps)
❒ Yes ❒ No Foods:___________________________________
❒ Yes ❒ No Other: ___________________________________

Please list any allergies or drug sensitivity: ___________________

____

List any drugs or medications now being taken, give reasons:

____

____

____

DENTAL HISTORY:

❒ Yes ❒ No History of jaw joint problems?
❒ Yes ❒ No Does patient clench their teeth?
❒ Yes ❒ No Does patient notice clicking or popping in either jaw joint?
❒ Yes ❒ No Does patient have difficulty chewing or opening their mouth?

❒ Yes ❒ No Has patient's jaw ever locked?
❒ Yes ❒ No Does patient's bite feel uncomfortable or unusual?
❒ Yes ❒ No Does patient experience soreness in the muscles of their face or around their ears?
❒ Yes ❒ No Has patient been diagnosed or treated for "TMJ" or "TMD" problems?

Have there been any injuries to the face, mouth or teeth? ❒ Yes ❒ No If yes, please explain: ____________________

Has the patient ever sucked a thumb or fingers? ❒ Yes ❒ No If yes, until what age? ____________________

Does the patient have any speech problems? ❒ Yes ❒ No ____________________

Have you been informed of any missing or extra permanent teeth? ❒ Yes ❒ No ____________________

Has an Orthodontist been consulted previously? ❒ Yes ❒ No

List any musical instruments played: ______________________________

REASON FOR CONSULTATION: ______________________________

____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in patient's medical status. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I also authorize the dental staff to perform the necessary orthodontic services as needed. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. This office reserves the right to verify the credit status of potential patients and or/ parents prior to extending credit for treatment fees. I understand that where appropriate, credit bureau reports will be obtained.

Parent/Guardian Signature ______________________ Parent/Guardian Signature ______________________

Print Name ______________________ Print Name ______________________