CHILD HEALTH HISTORY FORM

About Your Child

Today's Date _____

Patient's Name_____ Preferred Name/Nickname_____
Address_____
City_____ State_____ Zip_____ Home Phone_____
Birth Date_____/_____/_____ Age_____ Sex ❒ M ❒ F School_____ Grade_____

Parents or Guardians

Patient Lives With: ❒ Both Parents Separately ❒ Both Parents Together ❒ Mother ❒ Father ❒ Other_____
Father/Guardian_____ Employer_____ Cell Phone _____
Mother/Guardian_____ Employer_____ Cell Phone _____
Parent Address (if different from patient's) _____ E-Mail Address _____
City_____ State_____ Zip_____
How did you hear about our office?_____
What is the reason you are seeking an orthodontic evaluation?_____
Has an orthodontist been consulted previously? ❒ Yes ❒ No Reason:_____
Please list other family members seen in our office and their relationship to this patient: _____

Medical Health Information

Is patient adopted? ❒ Yes ❒ No At what age? _____
Name of your child's physician_____ Phone_____
Does your child have or has he/she had any of the following diseases or conditions? (Check those that apply.)

Yes	No		Yes	No		Yes	No	
❒	❒	Diabetes	❒	❒	Fainting Spells, Seizures	❒	❒	AIDS, HIV Positive
❒	❒	Stroke	❒	❒	Scarlet Fever, Rheumatic Heart Disease	❒	❒	Herpes, Fever Blisters
❒	❒	Asthma	❒	❒	Allergies (medicine or other)	❒	❒	Joint Replacement or Implant
❒	❒	Hepatitis	❒	❒	Latex or Nickel Sensitivity/Allergy	❒	❒	Excessive Bleeding or Bruising
❒	❒	Tonsillitis	❒	❒	High or Low Blood Pressure	❒	❒	Drug or Alcohol Dependency
❒	❒	Heart Defect, Heart Murmur, Heart Disease				❒	❒	Tonsils/Adenoids Removed

Does this patient now or has he/she ever taken bisphosphonates, including Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, or Zometa? ____ If so, which drug? _____ If female, has she begun menstruating? _____
Does your child have any disease, condition, or problem not listed that you think we should know about? Please explain:
_____
Is your child taking any medication at this time? ❒ Yes ❒ No If yes, please list: _____

Dental Insurance Information

Primary Insurance Company Name_____
Address_____ Group/Plan Number_____
Primary Policy Holder Name_____ Social Security Number____/____/_____ Date of Birth____/____/____
Secondary Insurance Company Name_____
Address_____ Group/Plan Number_____
Secondary Policy Holder Name_____ Social Security Number____/____/_____ Date of Birth____/____/____
Do you participate in a flex plan? **Y** or **N**

Dental Health Information

Is your child experiencing any dental problems? ❒ Yes ❒ No Date of last dental visit: ____/____/____
How often does your child brush and floss each day? Brushes____ times per day Flosses____ times per day
Child's Dentist_____ Phone_____
Does your child have or has he/she had any of the following diseases or problems?

Yes	No		Yes	No		Yes	No	
❒	❒	Tongue Thrust	❒	❒	Jaw Pain (Joint, Ear, Side of Face)	❒	❒	Extra Permanent Teeth
❒	❒	Sore or Bleeding Gums	❒	❒	Tooth Sensitivity to Heat, Cold or Sweets	❒	❒	Fear of Dental Work
❒	❒	Permanent Tooth Extraction	❒	❒	Previous Orthodontic Treatment	❒	❒	Clenching or Grinding
❒	❒	Difficulty Chewing	❒	❒	Head/Neck, Jaw or Tooth Injury	❒	❒	Finger or Lip Sucking Habit
❒	❒	Missing Permanent Teeth	❒	❒	Clicking or Popping of the Jaw Joints	❒	❒	Chronic Mouth Breather

Personal Information

Does the patient have any siblings? ❒ Yes ❒ No If yes, what are their ages? _____
Please list any special interests of the patient (sports, hobbies, etc.). _____
Patient's attitude toward orthodontic treatment: ❒ Very Motivated ❒ Will Cooperate (if needed) ❒ Not Motivated

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❒ Accept ❒ Decline

I acknowledge that the above information is correct. I will notify Dr. Fishbein of any changes that occur after this date.

I hereby authorize Dr. Fishbein and his team to perform an initial orthodontic evaluation/examination.

GUARDIAN SIGNATURE _____ DATE

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