

**HEALTH HISTORY AND REGISTRATION-CHILD**

Today's Date \_\_\_\_\_

Patient Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ Nickname \_\_\_\_\_  
Sex: M F Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_  
Hobbies, Sports: \_\_\_\_\_  
Names, ages of siblings: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Responsible Party Email Address \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_ General Dentist: \_\_\_\_\_  
Parent's Marital Status: Married Divorced Separated Single Widowed

**RESPONSIBLE PARTY INFORMATION**

Name Last: \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Work Phone # \_\_\_\_\_ Ext: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
SSN#: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Driver's License #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Employer: \_\_\_\_\_ Years Employed: \_\_\_\_\_

**RESPONSIBLE PARTY SPOUSE INFORMATION**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Employer: \_\_\_\_\_ Work #: \_\_\_\_\_ Ext: \_\_\_\_\_

**DENTAL INSURANCE**

Orthodontic Coverage? Yes No  
Insurance Company: \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_  
Insurance Company Phone # \_\_\_\_\_ Group # \_\_\_\_\_  
Insured's Name \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Insured's Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Employer: \_\_\_\_\_

**DENTAL HISTORY**

What are the main orthodontic concerns? \_\_\_\_\_  
\_\_\_\_\_  
Has your child ever been evaluated or had orthodontic treatment before? \_\_\_\_\_  
Has there been any injuries to the face, mouth, teeth, or chin? \_\_\_\_\_  
List any musical instruments played: \_\_\_\_\_  
Have the tonsils and/or adenoids been removed? \_\_\_\_\_ When? \_\_\_\_\_  
Has your child been informed of any missing or extra teeth? \_\_\_\_\_  
Does your child brush his/her teeth daily? \_\_\_\_\_ How many times? \_\_\_\_\_ Floss? \_\_\_\_\_  
Date of last dental visit: \_\_\_\_\_ Were the teeth cleaned? \_\_\_\_\_  
Circle if your child has or has had the following habits: Thumb/finger sucking Lip sucking/biting Nail biting  
Clenching/grinding teeth Mouth breather Speech problems

**MEDICAL HISTORY**

Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Please list all drugs your child is currently taking: \_\_\_\_\_  
Please list all drugs that your child is allergic to: \_\_\_\_\_  
Circle if your child has or has had any of the following: Heart Murmur Cancer Diabetes Rheumatic Fever  
HIV+/AIDS Hemophilia Asthma Hepatitis Tuberculosis Congenital heart defect Abnormal bleeding  
Convulsions/epilepsy Hearing impairment Kidney/liver problems Handicaps/disabilities Surgeries  
Any hospital stays Allergy to plastics, latex, or metals  
If "yes" to any, please explain \_\_\_\_\_  
Does your child need pre-medication for dental procedures? \_\_\_\_\_

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 it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. 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. I also understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all orthodontic fees. I also assign all insurance benefits to the Doctor. All payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the orthodontic fees incurred.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_ Dr.'s Signature \_\_\_\_\_