Concord orthodontics
The Orthodontic and Invisalign Specialist
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CHILD HEATH HISTORY FORM

Date:_____

PATIENT INFORMATION

Patient's Name:_____ DOB:_____ Age: _____
Last First Middle
Name patient prefers to be called: _____ Identifies as:_____
Patient's Home Address: _____ City: _____ State: _____ Zip:_____
Patient's Home Phone Number: _____
Parent's E-Mail (for appointment reminders, kept confidential):_____
Name and Ages of Other Family Members: _____
Patient's school name: _____ Grade: _____
Who may we thank for referring you to our office? _____
Who is accompanying this patient to their appointment? _____
Your name: _____ Your relationship to the patient: _____
Natural Parent Yes No Child Adopted Yes No Foster Parent Yes No Other:_____

PARENT INFORMATION

MOTHER
Mother's Marital Status: Married Divorced Widow Single Remarried
Name _____ Address_____ City_____ State_____ Zip_____
Home Phone _____ Work Phone _____ Employer _____
Cell Phone _____ Email Address _____

FATHER
Father's Marital Status: Married Divorced Widow Single Remarried
Name _____ Address_____ City_____ State_____ Zip_____
Home Phone _____ Work Phone _____ Employer _____
Cell Phone _____ Email Address _____

PERSON RESPONSIBLE FOR THIS ACCOUNT

Name _____ Address_____ City_____ State_____ Zip_____
SS# _____ Daytime Phone _____ Evening Phone _____

INSURANCE INFORMATION

Primary Insurance Information Relationship to Patient _____
Insured's Name _____ Insured's DOB_____ Insured's SS# _____
Employer: _____ Subscriber ID#: _____Group#_____
Insurance Company _____ City _____State _____ Zip _____
Insurance Phone _____ Name of Dental Plan _____

Secondary Insurance Information Relationship to Patient _____
Insured Name:_____ Insured's DOB: _____ Insured's SS# :_____
Insurance Company: _____ City: _____ State:_____ Zip: _____
Employer: _____ Subscriber ID#: _____Group#_____
Insurance Phone #: _____ Name of Dental Plan: _____

MEDICAL HISTORY

Physician _____ Date of last visit _____
Physician's Address _____ City _____ State _____ Zip _____

Please circle Yes or No (If yes, please fill in the details)

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Are you allergic to anything? If yes please describe. _____
Yes No Are you presently under care of a physician? _____
Yes No Do you have a major illness?_____
Yes No Have you ever been hospitalized? _____
Yes No Have you ever had your tonsils or adenoids removed? _____
Yes No Have you had any of the following? Asthma _____ Allergies _____ Hay fever ____ Throat Infections _____

Please circle the appropriate answer for the medical conditions below:

Yes	No	Active Heart Murmur	Yes	No	Endocrine Problems	Yes	No	Liver Disease
Yes	No	Asthma	Yes	No	Anemia	Yes	No	Epilepsy
Yes	No	Latex Allergy	Yes	No	AIDS	Yes	No	Arthritis
Yes	No	Lung/Respiratory	Yes	No	HIV+	Yes	No	Blood Disorder
Yes	No	Tuberculosis	Yes	No	Nervous Disorders	Yes	No	Abnormal Bleeding
Yes	No	Bone/Joint Disorders	Yes	No	Heart Problems	Yes	No	Pneumonia
Yes	No	Cancer/Tumor	Yes	No	Hepatitis-Type ____	Yes	No	Prolonged Bleeding
Yes	No	Diabetes	Yes	No	Herpes	Yes	No	Glaucoma
Yes	No	High Blood Pressure	Yes	No	Rheumatic Heart	Yes	No	Thyroid Disease
Yes	No	Dizziness/Fainting	Yes	No	Emotional Problems	Yes	No	Sinusitis
Yes	No	Kidney Involvement	Yes	No	Other _____			

DENTAL HISTORY

Dentist:_____ Phone #:_____Date of Last Visit: _____
Dentist's Address: _____ City: _____ State:_____ Zip:_____
What concerns you most about your teeth? _____

Please circle the appropriate answer to the following questions, and explain if need:

Yes No Have there ever been injuries to the face, mouth or teeth? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Do you have TMJ?_____
Yes No Are you aware of any jaw clicking or popping? _____
Yes No Have you ever been told that you grind your teeth? _____
Yes No Do you have "tension" or "frequent" headaches? _____
Yes No Have x-rays been taken recently? When? _____

Chief Concern for evaluation and information desired:_____
_____

Orthodontics is a service that provides an improvement in the appearance of the teeth and in the general function of the teeth, and general dental heath. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout lifetime and there can be some movement of the teeth and some change after treatment. It is my responsibility to inform the dental office of any changes in medical status. I authorize the doctor/office to release any information including diagnosis and the records of any treatment or examination rendered during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment for all services rendered on myself. I hereby state that I have read and understand the above paragraph and that I have truthfully to the best of my ability answered all the above questions.

Parent/Guardian Signature: _____ Date: _____