Child Health History Form

JACOBUS ORTHODONTICS
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1. Tell Us About Your Child

Today's Date: _____ ☐ Male ☐ Female

Child's Name: _____
LAST FIRST MI

Nickname: _____ SS #: _____

School: _____ Grade: _____

Hobbies / Sports: _____

Child's Home #: (___) _____

Child's Home Address: _____
APT / CONDO #

_____
CITY STATE ZIP

Birthdate: ___/___/___ Age: _____

2. Who Is Accompanying Your Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? _____
☐ Yes ☐ No

Whom may we Thank for referring you? _____

List brothers / sisters with age: _____

_____

General Dentist: _____

Last Visit Date: _____

Parent's Marital Status: ☐ Single ☐ Widowed
☐ Married ☐ Divorced ☐ Separated

3. Parent's Information

Mother's Information: ☐ Step Mother ☐ Guardian

Name: _____ Birthdate: ___/___/___

Work #: (___) _____ Ext.: _____ Home #: (___) _____

Employer: _____

Job Title: _____ How Long? _____

SS #: _____ DL #: _____

Father's Information: ☐ Step Father ☐ Guardian

Name: _____ Birthdate: ___/___/___

Work #: (___) _____ Ext.: _____ Home #: (___) _____

Employer: _____

Job Title: _____ How Long? _____

SS #: _____ DL #: _____

4. Person Responsible for Account

Name: _____ Relation: _____

Billing Address: _____
APT / CONDO #

_____
CITY STATE ZIP

Previous Address: _____
APT / CONDO #

_____
CITY STATE ZIP

Work #: (___) _____ Ext.: _____ Home #: (___) _____

Email Address: _____

Cell #: _____

Employer: _____

SS #: _____ DL #: _____

Who is responsible for making appointments? _____

Name: _____

Work #: (___) _____ Ext.: _____ Home #: (___) _____

5. Primary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (___) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ SS #: _____

Policy Owner's Employer: _____

Secondary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (___) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ SS #: _____

Policy Owner's Employer: _____

6. What are the main concerns that you would like orthodontic treatment to address?

_____

_____

_____

Has your child ever been evaluated or had orthodontic treatment before?
☐ Yes ☐ No

Have there been any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No

List any musical instruments played: _____

Have adenoids or tonsils been removed?
☐ Yes ☐ No

Has your child been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Has your child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)?
☐ Yes ☐ No

Does your child brush his / her teeth daily?
☐ Yes ☐ No

Floss his / her teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone #: (___) _____ Date of last visit: _____

Is your child currently under the care of a physician?
☐ Yes ☐ No

Has puberty begun? ☐ Yes ☐ No

Has menstruation begun? (Girls)
☐ Yes ☐ No

Please describe your child's current physical health:
☐ Good ☐ Fair ☐ Poor

Please list all drugs that your child is currently taking:

_____

Please list all drugs / things that your child is allergic to:

_____

7. Has your child ever had any of the following medical conditions?

Y	N	Abnormal Bleeding	Y	N	Diabetes
Y	N	Allergies to any Drugs	Y	N	Allergic to Plastic
Y	N	Handicaps/Disabilities	Y	N	Heart Murmur
Y	N	Hearing Impairment	Y	N	Any Hospital Stays
Y	N	Allergic to Latex/Metals	Y	N	Hemophilia
Y	N	Any Operations	Y	N	Hepatitis
Y	N	Kidney/Liver Problems	Y	N	Asthma
Y	N	Rheumatic/Scarlet Fever	Y	N	HIV+/AIDS
Y	N	Congenital Heart Defect	Y	N	Tuberculosis (TB)
Y	N	Convulsions/Epilepsy	Y	N	Cancer

Please discuss any medical problems that your child has had: _____

_____

_____

8. Does / did your child have any of the following habits?

Y	N	Clenching/Grinding Teeth	Y	N	Lip Sucking/Biting
Y	N	Nursing Bottle Habits	Y	N	Speech Problems
Y	N	Thumb/Finger Sucking	Y	N	Mouth Breather
Y	N	Nail Biting	Y	N	Tongue Thrust

Neighbor or Relative not living with you:

Name: _____ Phone: (___) _____

Address: _____
APT / CONDO #

_____
CITY STATE ZIP

9. 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 my child's medical status.

I authorize the dental staff to perform the necessary dental services my child may need.

_____
Signature of parent or guardian Date

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.

_____
Signature of parent or guardian Date

If this office accepts insurance, 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.

_____
Signature of parent or guardian Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Office Use Only

I verbally viewed the medical information with the parent/guardian and patient named herein.

Doctor's Comments: _____ Initials: _____ Date: _____

_____