"Dentistry Just For Kids"
and ORTHODONTICS

***BOTH

Health History (Please Print) Today's Date:_____

Patient's Name:_____ Goes By:_____ Age:_____

Patient's Address:_____ Birthdate:_____ Gender: M F

Patient Social Security#:_____ Patient's Home Telephone #:_____

Father's Information

Father's Name:_____ Cell #:_____ Marital Status: S / M / D

Father's Address:_____ City/St:_____ Zip:_____

Father's Social Security #:_____ Father's Birthdate:_____ Email:_____

Father's Employer:_____ Occupation: _____ Work Phone:_____

Mother's Information

Mother's Name:_____ Cell #:_____ Marital Status: S / M / D

Mothers's Address:_____ City/St:_____ Zip:_____

Mother's Social Security #:_____ Mother's Birthdate:_____ Email:_____

Mother's Employer:_____ Occupation:_____ Work Phone:_____

Alternate Contact Name:_____ Relationship _____ Phone:_____

Dental Insurance Information

Subscriber's Name:_____ ID/SS#:_____ Birthdate:_____

Dental Insurance Co.:_____ Ins. Phone #:_____ Group #:_____

Dental Claims Address:_____

Do you have Secondary Dental Insurance? Yes ☐ No ☐ If Yes:

Subscriber's Name:_____ ID/SS#:_____ Birthdate:_____

Dental Insurance Co.:_____ Ins. Phone #:_____ Group #:_____

Dental Claims Address:_____

Contractual financial arrangements for service fees will be subject to approval of credit and may require a credit report.

Whom May We Thank For Your Referral?_____

HIPAA

I acknowledge that I have received the Statement of Privacy Practices for the office of "Dentistry Just for Kids" and Orthodontics.

Signature:_____ **Date:**_____

"DENTISTRY JUST FOR KIDS" AND ORTHODONTICS- MEDICAL HISTORY FORM

PATIENT INFORMATION

If Patient is a Minor, Give Parent's or Guardian's Names (s): ☐ If yes

Have we ever treated any member(s) of your family? If Yes, Please list their names: ◯ Yes ◯ No If yes

MEDICAL HISTORY

Patient's Physician?

Is your child allergic to any of the following?

☐ Penicillin ☐ Codeine ☐ Latex

Are any of the following conditions present in patient's present or past history?

Abnormal Bleeding Problems	◯ Yes ◯ No	Epilepsy	◯ Yes ◯ No
AIDS or AIDS Related Complex	◯ Yes ◯ No	Fainting / Dizziness	◯ Yes ◯ No
Allergies (hayfever, pollen)	◯ Yes ◯ No	Hearing Problems	◯ Yes ◯ No
Allergies (medications, drugs)	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No
Anemia (including sickle cell)	◯ Yes ◯ No	Heart Problems	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Hyperactivity	◯ Yes ◯ No
Bladder Disorder	◯ Yes ◯ No	Kidney Disorders	◯ Yes ◯ No
Blood Disorder	◯ Yes ◯ No	Learning Disabilities	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Liver Disorders	◯ Yes ◯ No
Cerebral Palsy	◯ Yes ◯ No	Convulsions or Seizures	◯ Yes ◯ No
Premature Delivery	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No
Radiation Therapy	◯ Yes ◯ No	Ear, Nose, or Throat Problems	◯ Yes ◯ No
Emotional Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No
Thyroid (High or Low)	◯ Yes ◯ No	Tonsils Removed	◯ Yes ◯ No
Neck Ache / Stiff Neck Muscles	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Tuberculosis	◯ Yes ◯ No		

Is your child presently taking any medication? If yes, please list. ◯ Yes ◯ No If yes

Has your child ever been hospitalized? If yes, for what reason? ◯ Yes ◯ No If yes

Has your child or any family members had a problem under general anesthesia? ◯ Yes ◯ No If yes

Has your child ever received a blood transfusion? If yes, what year? ◯ Yes ◯ No If yes

Does your child have any special problems not listed above? If yes, please list. ◯ Yes ◯ No If yes

DENTAL HISTORY

Last Visit to the Dentist, Date and Reason for the Visit? omment

Have any teeth (including baby teeth) been extracted by a Dentist? ◯ Yes ◯ No

Have any permanent teeth evey been injured or loosened by a fall? ◯ Yes ◯ No

Does the patient have speech problems? ◯ Yes ◯ No

Does the patient have any of the following habits and/or conditions:

☐ Thumb Sucking ☐ Mouth Breathing ☐ Nail Biting ☐ Clenching, Grinding, Teeth
☐ Popping, Clicking in Jaw Joint ☐ Hurts to Chew ☐ Hurts to Open Mouth Wide ☐ Facial, Joint, or Eye Pain

Who brushes child's teeth and how many times per day? N/A for Orthodontic Patients

Do you have well or city water?

Any current dental problems? If yes, please explain. ◯ Yes ◯ No If yes

Any unhappy dental visits? If yes, please explain. ◯ Yes ◯ No If yes

Any history of injuries to mouth, teeth, head? If yes, please explain. ◯ Yes ◯ No If yes