FOREST HILL
FAMILY ORTHODONTICS

NEW PATIENT HISTORY FORM - CHILD

Patient Name: _____ DOB:_____/_____/_____ Age:_____
(First) (middle Initial) (Last)

Patient Address _____
(Street Address) (City) (State) (Zip)

Mothers Name _____ ☐Married ☐Divoirced ☐Single ☐Widowed DOB:_____/_____/_____
(First) (Last)

Phone:_____Email:_____Address (if different)_____

Fathers Name _____ ☐Married ☐Divoirced ☐Single ☐Widowed DOB:_____/_____/_____
(First) (Last)

Phone:_____Email:_____Address (if different)_____

1) Siblings Name: _____ DOB_____ 2)Siblings Name: _____ DOB_____

How did you hear about us?/ Who referred you to us? ☐ Google ☐ Radio ☐ Facebook ☐ Groupon ☐ Instagram

Referral:_____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account*:*_____DOB:_____/_____/_____
(First) (Last)

Address (if different) _____
(Street Address) (City) (State) (Zip)

Phone number: _____ Email:_____ Relationship:_____

Occupation:_____Employer:_____ SSN:_____

DENTAL INSURANCE INFORMATION

Does your child have Dental Insurance: ☐*YES* ☐NO

Insurance Company:_____ Member/Subscriber ID: _____

Primary Holders Name: _____ DOB:_____/_____/_____
(First) (middle Initial) (Last)

Occupation:_____Employer:_____ SSN:_____

Relationship to Patient: _____ Insurance Address: _____

Insurance provider phone number:_____ Insurance Group #_____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

DENTIST INFORMATION ☐ I do not have a Dentist

Patient's Dentist _____ Name of the practice_____

Phone Number:_____Last visit:_____

Last Cleaning:_____Next visit: _____

PATIENT HEALT INFORMATION

Does your child had/has any allergies or reactions to any of the following?

☐ No Known Drug Allergies (KNDA)

☐ Latex (gloves, balloons)	☐ Metals (jewelry, clothing snaps)	☐ Acetaminophen/Tylenol
☐ Aspirin	☐ Penicillin	☐ Ibuprofen (Motrin, Advil)

List any medication that your child takes:

1) _____ 2) _____ 3) _____ 4) _____

5)_____ 6) _____ 7) _____ 8) _____

DENTAL HISTORY

(check if your child has had any problems with the following)

☐ Bad Breath	☐ Supernumerary teeth	☐ History of speech problems/therapy
☐ Bleeding Gums	☐ Congenitally missing teeth	☐ Self-conscious about your teeth
☐ Clicking or popping Jaw	☐ Jaw fractures cysts or mouth infections	☐ Frequent canker sores or cold sores
☐ Grinding teeth,jaw clenching, locking	☐ Soreness in jaw muscles or face muscles	☐ Wisdom tooth problems.Date removed?
☐ Loose teeth or broken feelings	☐ Difficulty opening Jaw or chewing	☐ Prior orthodontic examination treatment. Date of past treatment?
☐ Periodontal treatment	☐ Muscles or face muscles	☐ Presently wearing retainer mouth-guard
☐ Sensitivity to cold/hot,or pain	☐ Thumb, finger or sucking habit. Until what age?	☐ Normally breath with lips parted
☐ Teeth removed for any reason		☐ NONE OF THE ABOVE
☐ "Dead teeth" or route canals treated		
☐ Snoring, sleep apnea? PSG test date		

MEDICAL HISTORY

(check if your child has had any problems with the following)

Physicians Name:_____ Date of last visit:_____

Has your child had any serious illness or operations, if yes describe:_____

☐ Aids/HIV positive	☐ Heart murmur	☐ Respiratory disease
☐ Tuberculosis	☐ Pacemaker	☐ Thyroid problems
☐ Arthritis, Rheumatism	☐ Chemical dependency	☐ Liver disease
☐ Artificial heart valves	☐ Radiation therapy	☐ Stroke
☐ Artificial joints	☐ Nervous problems	☐ Glaucoma
☐ Back problems	☐ Shortness of breath	☐ Heart problem
☐ Chemotherapy	☐ Psychiatrist care	☐ Scarlet fever
☐ Blood disease	☐ Hepatitis	☐ Ulcer
☐ Kidney problems	☐ Jaw pain	☐ Hemophilia
☐ Venereal disease	☐ High blood pressure	☐ Asthma
☐ Tobacco habit	☐ Mitral valve prolapse	☐ Headaches
☐ Diabetes	☐ Remote rheumatic fever	☐ Anemia
☐ Epilepsy	☐ Circulatory problems	☐ NONE OF THE ABOVE
☐ Fainting	☐ Cancer	

BENEFITS

Benefits of orthodontics:Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in the general dental health. I understand that my diagnostic records maybe use for educational and promotional purposes. I authorize released of any information regarding my orthodontic treatment to my dental and/or medical insurance company. I will not hold my orthodontist or any member of the staff responsible for any errors or omissions that I have made in the completion of this form. I have truthfully answered all the above questions and agreed to inform this office of any changes in the medical or dental history. I acknowledge having received a copy of the practice notice of privacy practices practices

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I authorize release of any information regarding my orthodontic treatment to my dental insurance company.

Patient Name: _____DOB: _____

Parent/Guardian Name: _____ DOB: _____

Responsibly Party Signature _____Date signed:_____