Child & Adolescent Patient Information Form

FOREST BEDFORD
FARMVILLE KEYSVILLE
MADISON HEIGHTS
434-385-4499

Tell Us About Your Child

Today's Date: ______________

Patient's Last Name: _______________ First Name: _____________ Middle Name/Initial: _____________

Prefers to be Called: _______________ Birthdate: ___________ Age: ______ Sex: Male ☐ Female ☐

Email Address: __________________________

Street Address: ________________________________ City: ____________ State: _____ Zip: ______

Phone: (______)____________ School: ________________ Grade: ____

Hobbies/sports: ____

General Information

Who is accompanying the child to the first visit? __________________________ Relation: _______________

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

Other siblings/ages: ______________________ Names of family members treated here: _______________________

Who suggested that your child might need orthodontic treatment? ____

Why did you select our office? ____

Whom may we thank for referring you? ____

Name of Patient's Dentist: ________________________ Phone: (____)____________

Date Last Seen: ____________ Reason: ____

Has your child had a previous orthodontic examination or treatment? ☐ Yes ☐ No

Name of Patient's Physician: ______________________ Phone: (____)____________

Date Last Seen: ____________ Reason: ____

Parents' Information

Who is financially responsible for the account? ____
(If there is more than one responsible party and the parties are not married to each other, indicate the percentage that each will pay.)

Parents' Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

☐ **Father** ☐ Stepfather ☐ Guardian Title: ☐ Mr. ☐ Dr. ☐ Rev.

Name: _________________________________ Birthdate: _________ SSN: ____________

Home Phone: (___)__________ Cell Phone: (___)__________ Email: __________________

Street Address: (if different than child's) ____

City: ______________________ State: _____ Zip: _______

Father's Employer: ________________________ Occupation: ______________ Work Phone: (_____)____________

Insurance Coverage for Dental Treatment? Yes ☐ No ☐ Insurance Coverage for Orthodontic Treatment? Yes ☐ No ☐

Insurance Co. Name: ______________________ Insurance Address: ____

Insurance Phone: (_____)__________________ Insured's ID#: ___________________ Group #: ________________

☐ **Mother** ☐ Stepmother ☐ Guardian Title: ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev.

Name: ____________________ Birthdate: _________ SSN: ____________

Home Phone: (_____)_______________ Cell Phone: (_____)_____________ Email: ____________________

Street Address: (if different than child's) ____

City: ______________________ State: _____ Zip: _______

Mother's Employer: ________________________ Occupation: ______________ Work Phone: (_____)____________

Insurance Coverage for Dental Treatment? Yes ☐ No ☐ Insurance Coverage for Orthodontic Treatment? Yes ☐ No ☐

Insurance Co. Name: ______________________ Insurance Address: ____

Insurance Phone: (_____)__________________ Insured's ID#: ___________________ Group #: ________________

Medical History

For the following questions mark yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Patient Profile

- ☐ yes ☐ no ☐dk/u Does patient follow directions well?
- ☐ yes ☐ no ☐dk/u Does patient brush his/her teeth conscientiously?
- ☐ yes ☐ no ☐dk/u Does patient have learning disabilities or need extra help with instructions?
- ☐ yes ☐ no ☐dk/u Is patient sensitive or self-conscious about teeth?

Now or in the past, has the patient had:

- ☐ yes ☐ no ☐dk/u Birth defects or hereditary problems?
- ☐ yes ☐ no ☐dk/u Rheumatoid or arthritic conditions?
- ☐ yes ☐ no ☐dk/u Endocrine or thyroid problems?
- ☐ yes ☐ no ☐dk/u Kidney problems?
- ☐ yes ☐ no ☐dk/u Diabetes?
- ☐ yes ☐ no ☐dk/u Cancer, tumor, radiation treatment, or chemotherapy?
- ☐ yes ☐ no ☐dk/u Stomach ulcer or hyperacidity?
- ☐ yes ☐ no ☐dk/u Polio, mononucleosis, tuberculosis or pneumonia?
- ☐ yes ☐ no ☐dk/u Problems of the immune system?
- ☐ yes ☐ no ☐dk/u AIDS or HIV positive?
- ☐ yes ☐ no ☐dk/u Hepatitis, jaundice or liver problems?
- ☐ yes ☐ no ☐dk/u Fainting spells, seizures, epilepsy or neurological problem?
- ☐ yes ☐ no ☐dk/u Mental health disturbance or behavioral problem?
- ☐ yes ☐ no ☐dk/u Vision, hearing, tasting or speech difficulties?
- ☐ yes ☐ no ☐dk/u History of eating disorder (anorexia, bulimia)?
- ☐ yes ☐ no ☐dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?
- ☐ yes ☐ no ☐dk/u High or low blood pressure
- ☐ yes ☐ no ☐dk/u Chest pain, shortness of breath or swelling ankles?
- ☐ yes ☐ no ☐dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease?
- ☐ yes ☐ no ☐dk/u Frequent headaches, colds or sore throats?
- ☐ yes ☐ no ☐dk/u Eye, ear, nose or throat condition?
- ☐ yes ☐ no ☐dk/u Hayfever, asthma, sinus trouble or hives?
- ☐ yes ☐ no ☐dk/u Tonsil or adenoid conditions?

Allergies or reactions to any of the following:

- ☐ yes ☐ no ☐dk/u Antibiotics (specify) ____________________________ ____________________________
- ☐ yes ☐ no ☐dk/u Other drugs (specify) ____________________________ ____________________________
- ☐ yes ☐ no ☐dk/u Nickel
- ☐ yes ☐ no ☐dk/u Latex (gloves, balloons)
- ☐ yes ☐ no ☐dk/u Other substances (specify) ______________________

☐ yes ☐ no ☐dk/u Is the patient taking medication, nutrient supplements, herbal medications or non-prescription medicine? Please name them.

Medication ____________ Taken for ____________________________

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Medication ____________ Taken for ____________________________

☐ yes ☐ no ☐dk/u Does the patient require antibiotic premedication prior to dental procedures?

☐ yes ☐ no ☐dk/u Does the patient currently have or ever had a substance abuse problem?

☐ yes ☐ no ☐dk/u Does the patient chew or smoke tobacco?

☐ yes ☐ no ☐dk/u Operations? Describe: ________________________

☐ yes ☐ no ☐dk/u Hospitalized? For: ___________________________

☐ yes ☐ no ☐dk/u Other physical problems or symptoms?

Describe: ____________________________________

☐ yes ☐ no ☐dk/u Being treated by another health care professional?

For: ____

☐ yes ☐ no ☐dk/u Are there any other medical conditions that we should be aware of?

____

Dental History

☐ yes ☐ no ☐dk/u Started teething very early or late?

☐ yes ☐ no ☐dk/u Primary (baby) teeth removed that were not loose?

☐ yes ☐ no ☐dk/u Any extra or missing permanent teeth? (specify which)

____

☐ yes ☐ no ☐dk/u Chipped or otherwise injured primary (baby) or permanent teeth?

☐ yes ☐ no ☐dk/u Teeth sensitive to hot or cold; teeth throb or ache?

☐ yes ☐ no ☐dk/u Jaw fractures, cysts or mouth infections?

☐ yes ☐ no ☐dk/u "Dead teeth" or root canals treated?

☐ yes ☐ no ☐dk/u Bleeding gums, bad taste or mouth odor?

☐ yes ☐ no ☐dk/u Periodontal "gum problems"?

☐ yes ☐ no ☐dk/u Food impaction between teeth?

☐ yes ☐ no ☐dk/u Thumb, finger, or sucking habit? Until what age? ______

☐ yes ☐ no ☐dk/u Abnormal swallowing habit (tongue thrusting)?

☐ yes ☐ no ☐dk/u History of speech problems?

☐ yes ☐ no ☐dk/u Mouth breathing habit, snoring or difficulty breathing?

☐ yes ☐ no ☐dk/u Tooth grinding, jaw clenching, clicking or locking?

☐ yes ☐ no ☐dk/u Any pain in jaw or ringing in the ears?

☐ yes ☐ no ☐dk/u Any pain or soreness in the muscles of the face or around the ears?

☐ yes ☐ no ☐dk/u Difficulty encountered in chewing or jaw opening?

☐ yes ☐ no ☐dk/u Aware of loose, broken or missing restorations (fillings)?

☐ yes ☐ no ☐dk/u Any teeth irritating cheek, lip, tongue or palate?

☐ yes ☐ no ☐dk/u Concerned about spaced, crooked or protruding teeth?

☐ yes ☐ no ☐dk/u Aware or concerned about under or over developed jaw?

☐ yes ☐ no ☐dk/u "Gum boils", frequent canker sores or cold sores?

☐ yes ☐ no ☐dk/u Taking any forms of fluoride?

☐ yes ☐ no ☐dk/u Any relative with similar tooth or jaw relationships?

☐ yes ☐ no ☐dk/u Had periodontal (gum) treatment?

☐ yes ☐ no ☐dk/u Would patient object to wearing orthodontic appliances (braces) should they be indicated?

☐ yes ☐ no ☐dk/u Any serious trouble associated with previous dental treatment?

☐ yes ☐ no ☐dk/u Been under another dental specialist's care?

☐ yes ☐ no ☐dk/u Is there anything you would like to discuss with the orthodontist in private?

Girls Only

☐ yes ☐ no ☐dk/u Has the patient started her monthly periods? If so, at what age? ___________

☐ yes ☐ no ☐dk/u Is the patient pregnant?

How often does your child brush? ______________________ Floss? ___________________________

What is your primary concern? Why are you here? ____

Authorization

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

I understand that Orthodontic Arts will assist me in filing claims for insurance benefits. I hereby authorize the orthodontist to release all information necessary to secure the payment of insurance benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions whether manual or electronic. <u>I understand that Orthodontic Arts does not take responsibility for the recovery of insurance benefits from my insurance carrier and that I am responsible for payment of all services rendered.</u>

Signed: ____ Date Signed: __________________________________
(Parent or Guardian)

Signed: ____ Date Signed: __________________________________
(Doctor or Staff Member)