ARIZONA ORTHODONTICS EXCLUSIVELY, PC

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www.arizonaorthodonticsexclusively.com

Orthodontics for children and adults

CHILD HEALTH HISTORY FORM

Welcome! Our specialty is creating smiles, and to do this we treat people, not just teeth! We are about your total health and appreciate your time in this health history.

DATE:____________________________________

PATIENT INFORMATION

Child's Name____ Child's DOB____/____/____ Age_______
Last First Middle □Male □Female Height_____ Weight ________
Name Child prefers to be called______________________________________
Child's Home Address______________________________________City ___________________State________Zip__________
Child's Home Phone #_______________________________
Child's School Name____Grade____
Parent E-Mail Address (used for appointment reminders/x-ray & photo viewing, kept confidential): ____________________________
Sports/Hobbies____Musical Instrument Played________________________
Names and Ages of Other Family Members____
Names of Other Family Members Treated in this Office____

Who may we thank for referring you to our Office? ____

Who is accompanying this child today? ____

Your Name _______________________________________ Your relationship to Child_____________________________________
(Natural Parent? □Yes □No) (Child Adopted □Yes □ No) (Foster Parent? □Yes □No) (Other- Specify Relationship______________________

PARENT'S INFORMATION

Mother's Marital Status □ Married □ Divorced □ Widow □ Single □ Remarried
□ Mother □ Stepmother □ Guardian
Name________________________ Address________________________________City________________State_______Zip_________
Home Ph .____________________________Work Ph.________________________ Employer_______________________
Father's Marital Status □ Married □ Divorced □ Widow □ Single □ Remarried
□ Father □ Stepfather □Guardian
Name_________________________Address________________________________City________________State________Zip_________
Work Ph.________________________ Employer ______________________

PERSON(S) RESPONSIBLE FOR THIS ACCOUNT

Name_________________________________Address_________________________City_________________State________Zip________
SS #__________________________________Daytime Phone #_________________________Evening Phone #_______________________
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 SS #_________________
Employer's Name____________________________________ Employer's Phone #_______________________________________
Employer's Address __________________________________City ______________________State _____________Zip____________
Insurance Company__________________________________ City ______________________ State _____________ Zip ___________
Insurance Phone # ___________________________________ Name of Dental Plan ____________________________________

(***We will need a copy of your "Dental Plan Insurance Card***")

Secondary Insurance Information Relationship to Patient____
Insured's Name_____________________________________ Insured's DOB ___________________Insured SS #_________________
Employer's Name____________________________________ Employer's Phone #_______________________________________
Employer's Address __________________________________City ______________________State _____________Zip____________
Insurance Company__________________________________ City ______________________ State _____________ Zip ___________
Insurance Phone # ___________________________________ Name of Dental Plan ____________________________________

(***We will need a copy of your "Dental Plan Insurance Card***")

(Continued on Opposite Side)

Reviewed with patient by____ Date ____

MEDICAL HISTORY

Physician ____ Date of Last Visit ____
Physician's Address ___________________________ City___________________ State ________Zip __________ Phone # ____________

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 presently under care of a physician? Yes No Do you have a history of major illness?______________________
Yes No Have you ever had any major operation? Yes No Ever been hospitalized?____________________________________
Yes No Have you ever been involved in a serious accident? ____
Yes No Have you had your tonsils or adenoids removed? ____
Yes No Have you ever had any of the following: Asthma_______ Allergies _______ Hayfever _______Throat Infections _______
If so, what are you allergic to? ____

Please circle the appropriate answer for the medical conditions below:

Yes	No	Abnormal Bleeding	Yes	No	Endocrine Problems	Yes	No	Liver Disease	Yes	No	Tuberculosis
Yes	No	Anemia	Yes	No	Epilepsy	Yes	No	Lung/Respiratory Disease	Yes	No	AIDS
Yes	No	Arthritis	Yes	No	Glaucoma				Yes	No	HIV +
Yes	No	Blood Disorders	Yes	No	Heart Murmur	Yes	No	Nervous Disorders	Yes	No	Contact Lenses
Yes	No	Bone or Joint Disorders	Yes	No	Heart Problems	Yes	No	Pneumonia	Yes	No	Other________
			Yes	No	Hepatitis-Type___	Yes	No	Prolonged Bleeding			If a child, have you reached puberty? Yes No
Yes	No	Cancer/Tumor	Yes	No	Herpes	Yes	No	Rheumatic Fever			
Yes	No	Diabetes	Yes	No	High Blood Pressure	Yes	No	Rheumatic Heart			Girls, have you started menstruation? Yes No
Yes	No	Dizziness/Fainting	Yes	No	Hyperactive	Yes	No	Thyroid Disease			
Yes	No	Emotional Problems	Yes	No	Kidney Involvement	Yes	No	Sinusitis			Boys, has your voice changed yet? Yes No

DENTAL HISTORY

Dentist____Date of Last Visit___________________________
Dentist's Address________________________City_________________________State________Zip__________Phone # ___________

What concerns you most about your teeth? ____
Does the patient want the teeth straightened? ____
What Is Your Chief Concern? ____

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

Yes No Have there ever been any injuries to the face, mouth or teeth? ______________________________________
Yes No Have you ever been informed of missing, extra or chipped teeth? ____________________________________
Yes No Have you ever had any abscessed teeth? ____
Yes No Is any part of your mouth sensitive to temperature or pressure? _______________________________________
Yes No Do your gums bleed when you brush your teeth? ____
Yes No Do you have any type of thumb or tongue habit? ____
Yes No Have you ever had any speech therapy? If yes, how long? ____
Do you breathe mostly through the: nose______ mouth ______ both ______ uncertain ______
Yes No Do you have TMJ? ____
Yes No Are you aware of any joint noise? ____
Yes No Do you have any facial pain? ____
Yes No Do you have any pain or soreness around your face, neck or back? ____________________________________
Yes No Are your teeth or jaws ever uncomfortable when you awaken in the morning? _____________________________
Yes No Are you aware of jaw clicking or popping? ____
Yes No Are you aware of clenching your teeth during the day? ____
Yes No Have you ever been told that you grind your teeth? ____
Yes No Do you have "tension" headaches? ____
Yes No Do you have "frequent" headaches? ____
Yes No Have you ever experienced chronic ringing in your ears? _______________________________________
Yes No Have you or anyone in your family had orthodontics? ____
Yes No Does the patient resemble Mother and/or Father? ____
Yes No Does anyone in the family have similar dental condition? ______________________________________

BENEFITS OF ORTHODONTICS

Aesthetics, Health and Function

Orthodontics is a service that provides an improvement in the appearance of the teeth, and in the general function of the teeth, and in general dental health. 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 our lifetime, and there can be some movement of the teeth, and some change after treatment. 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.

Patient/Patient Signature Date