



New Patient Health History - Child

# Please complete this form with your child's information

### 1. Patient Information:

First Name: \_\_\_\_\_ Middle Initials: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Female  Male

Street Address: \_\_\_\_\_ Apt./Unit #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Preferred contact method:  
 Mobile Phone  Home Phone  Work Phone  Email  None

### 2. Primary Responsible Party Information:

First Name: \_\_\_\_\_ Middle Initials: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Female  Male Marital Status:  Single  Married

Street Address: \_\_\_\_\_ Apt./Unit #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Preferred contact method:  
 Mobile Phone  Home Phone  Work Phone  Email  Text

### 3. Secondary Responsible Party Information (optional):

First Name: \_\_\_\_\_ Middle Initials: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Female  Male  Other Marital Status:  Single  Married

Street Address: \_\_\_\_\_ Apt./Unit #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Preferred contact method:  
 Mobile Phone  Home Phone  Work Phone  Email  Text

### 4. How did you learn about our practice or whom may we thank for referring you?

Referral Source  
 Google  Dentist  Social Media  Sign or billboard  Insurance Provider List

Friend or family (enter name)

Other Website

Other

**5. What is your primary concern(s)?**

**6. Has your child had previous orthodontic treatment?**

Yes

No

**7. General Dentist Information:**

Dentist Name:

Dental visit in last 6 months?:

Any scheduled treatments?

Yes  No

**8. Do you have Dental Insurance?**

Yes

No

Not Sure

**9. Primary Insurance**

Primary Insurance Company

Member ID / Policy #

Group Number

Patient Relationship to Insured

Insured Name

Insured Phone #

Insured Date of Birth

Self  Spouse  Child

Other

Insured Street Address

Insured City

Insured State

Zip Code

**10. Primary Insurance Card: Please take a photo of the back and front of your insurance card. Should treatment be recommended, providing your insurance card will allow us to share the portion of your orthodontic treatment fee covered by your plan.**

**11. Secondary Dental Insurance**

Secondary Insurance Company

Member ID / Policy #

Group Number

Patient Relationship to Insured

Insured Name

Insured Phone #

Insured Date of Birth

Self  Spouse  Child

Other

Insured Street Address

Insured City

Insured State

Zip Code

**12. Secondary Insurance Card: Please take a photo of the back and front of your insurance card. Should treatment be recommended, providing your insurance card will allow us to share the portion of your orthodontic treatment fee covered by your plan.**

**13. Check if your child has or has had any of the following:**

Anemia

Asthma/COPD

Bleeding abnormally

Cancer Treatment

Diabetes

Epilepsy

Fainting

GERD/Acid Reflux

Headaches/Migraines

Heart problems

Hepatitis

High blood pressure

HIV AIDS

Osteoporosis

Pacemaker

Rheumatic fever

Stroke

Tobacco use

**Other/Details:**

**14. Indicate any history of (check all that apply); If checked "Yes", please explain.**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Thumb/finger sucking             | <input type="checkbox"/> Tongue and/or swallowing problems        | <input type="checkbox"/> Speech problems                       |
| <input type="checkbox"/> Loose teeth or broken fillings   | <input type="checkbox"/> Grinding and/or clenching of teeth       | <input type="checkbox"/> Tonsils and adenoids removed          |
| <input type="checkbox"/> Crowns/Bridges                   | <input type="checkbox"/> Root canals                              | <input type="checkbox"/> Mouth breathing                       |
| <input type="checkbox"/> Snoring                          | <input type="checkbox"/> History of wearing a mouthguard at night | <input type="checkbox"/> History of Periodontal disease        |
| <input type="checkbox"/> History of Periodontal treatment | <input type="checkbox"/> Mouth sores                              | <input type="checkbox"/> Injury to face or teeth               |
| <input type="checkbox"/> Jaw Pain                         | <input type="checkbox"/> Clicking or popping jaw                  | <input type="checkbox"/> Difficulty opening or closing jaw     |
| <input type="checkbox"/> Sensitivity when biting          | <input type="checkbox"/> Cold, hot, or sweets sensitivity         | <input type="checkbox"/> Food collection between certain teeth |

**Other/Details:**

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**15. Has patient reached puberty?**

- Yes  No

**16. Please list any allergies:**

	Allergy
1	

**17. List current medications and the correlating diagnosis:**

	Medication	Diagnosis
1		

**18. Any serious illnesses or operations? If yes, please describe.**

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**19. What treatment option(s) interest you?**

- Aligners  Clear/Metal Braces  Retainers

**20. If treatment is recommended, how soon would you like to get started?**

- ASAP  Within the week  Within the month

**Other:**

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**21. What payment option(s) would you like to review?**

- No-Interest Monthly Payment  Payment in Full w/Special Courtesy  HSA/FSA

**22. Is there anything else you would like us to know before your visit?:**

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To the best of my knowledge, the above questions have been accurately answered. I am aware it is my responsibility to inform this office of any changes to my medical status. I permit to perform necessary orthodontic records, and I am aware you may use these records for in-office education.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date