

CHILD Registration and Health History Form

Patient's name _____ Social Security # _____

Nickname _____ Age _____ Sex _____ Birthdate _____

Address _____ City & Zip _____

Father's name _____ Occupation _____

Employer _____ How many years? _____ Business phone _____

Mother's name _____ Occupation _____

Employer _____ How many years? _____ Business phone _____

Home Telephone _____ Mobile Telephone _____ (mother father)

Whenever possible, we try to give a courtesy (confirmation) call before your appointments. Which phone number would you like us to use? _____ Preferred email contact _____ (mother father)

Parent's Marital Status Single Married Widowed Separated Divorced

Person financially responsible for the account _____

If there is orthodontic insurance, Insured's Social Security Number _____ Date of Birth _____

Whom do we contact in case of an emergency (Other than parent)? _____ Tel _____

Father's / Mother's address if different from patient _____

Brothers' / Sisters' names and birthdates _____

Has anyone in the family had orthodontic care? (who?) _____

Is the patient adopted? _____ If "Yes", does the patient know? _____

Patient's physician _____ Telephone _____

Patient's dentist _____ Date of last dental cleaning _____

What are the patient's hobbies and sports? _____

Patient's school _____ Grade _____ Musical Instruments played _____

Whom may we thank for referring you to our office? _____

Do you have any friends or relatives who come to our office? _____

Who noticed orthodontic problem? Patient Parent Dentist Other _____

Describe the orthodontic concern in your own words: _____

Special requests / considerations or comments: _____

PATIENT'S NAME _____ Height _____ Weight _____

An Explanation...

It is our desire to offer the finest treatment for you and/or your child. In order to plan the best treatment, it is important that we understand the medical/dental background of our patients. While some of the questions may seem personal, the answers may be very important to our planned orthodontic treatment. Thank you for your cooperation.

- Is the patient under the care of a physician? (who and why?) yes no
- Does the patient have a health problem now? (what?) yes no
- Is the patient presently taking **any** medications? (what?) yes no
- Is any antibiotic necessary for dental procedures? (what?) yes no
- Does patient have learning disabilities or needs extra help with instructions? yes no
- Does the patient have any allergies? (metals, latex, hay fever, other?) yes no
- Have the tonsils and/or adenoids been removed? (what and when?) yes no
- Is there a history of ear infection, sore throats, or frequent colds? (which and how frequent?) yes no
- Has the patient been hospitalized in the past three years? (diagnosed condition?)..... yes no
- Does the patient have any mental or physical disability? (what?) yes no
- Is there a history of injury to face, head, or teeth? (what and when?) yes no
- Does the patient have problems or pain in the jaw joint (TMJ) or soreness in jaw muscles?..... yes no
- Tooth grinding, jaw clenching, or any clicking, locking in jaw? yes no
- Does the patient have bleeding gums, gum problems, or history of periodontal (gum) treatment? yes no
- Is there a history of mouth breathing, snoring, or difficulty breathing? (reasons?) yes no
- Is there a history of finger or thumb sucking? (how long?) yes no

What are the chief concerns you have related to the position of your child's teeth or bite:

- Aesthetic Cleaning Comfort Ability to chew Stability Other: _____

Does the patient chew or smoke tobacco?.. yes no Any history of a substance abuse problem? . yes no

Girls only: Started her monthly period? (when?)..... yes no Is the patient pregnant?..... yes no

Boys: Has his voice changed? (When?) yes no

Has the patient ever had any of the following:

- | | | | | | |
|-------------------------|--|------------------------------|--|-----------------------------|--|
| AIDS or HIV positive | <input type="checkbox"/> yes <input type="checkbox"/> no | cytomegalovirus | <input type="checkbox"/> yes <input type="checkbox"/> no | measles/mumps | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Arthritis | <input type="checkbox"/> yes <input type="checkbox"/> no | diabetes | <input type="checkbox"/> yes <input type="checkbox"/> no | mononucleosis/polio | <input type="checkbox"/> yes <input type="checkbox"/> no |
| anemia | <input type="checkbox"/> yes <input type="checkbox"/> no | epilepsy/seizures | <input type="checkbox"/> yes <input type="checkbox"/> no | organ transplant | <input type="checkbox"/> yes <input type="checkbox"/> no |
| rheumatoid condition | <input type="checkbox"/> yes <input type="checkbox"/> no | heart murmur | <input type="checkbox"/> yes <input type="checkbox"/> no | problems with immune system | <input type="checkbox"/> yes <input type="checkbox"/> no |
| asthma | <input type="checkbox"/> yes <input type="checkbox"/> no | cardiovascular/heart trouble | <input type="checkbox"/> yes <input type="checkbox"/> no | psychiatric treatment | <input type="checkbox"/> yes <input type="checkbox"/> no |
| bleeding disorder | <input type="checkbox"/> yes <input type="checkbox"/> no | hepatitis | <input type="checkbox"/> yes <input type="checkbox"/> no | shortness of breath | <input type="checkbox"/> yes <input type="checkbox"/> no |
| cancer treatment | <input type="checkbox"/> yes <input type="checkbox"/> no | herpes (any type) | <input type="checkbox"/> yes <input type="checkbox"/> no | sinus trouble | <input type="checkbox"/> yes <input type="checkbox"/> no |
| canker sores | <input type="checkbox"/> yes <input type="checkbox"/> no | high or low blood pressure | <input type="checkbox"/> yes <input type="checkbox"/> no | stroke | <input type="checkbox"/> yes <input type="checkbox"/> no |
| chicken pox | <input type="checkbox"/> yes <input type="checkbox"/> no | endocrine/thyroid problems | <input type="checkbox"/> yes <input type="checkbox"/> no | swelling of ankles | <input type="checkbox"/> yes <input type="checkbox"/> no |
| chronic cough | <input type="checkbox"/> yes <input type="checkbox"/> no | jaundice/liver problems | <input type="checkbox"/> yes <input type="checkbox"/> no | tuberculosis | <input type="checkbox"/> yes <input type="checkbox"/> no |
| congenital heart lesion | <input type="checkbox"/> yes <input type="checkbox"/> no | kidney problems | <input type="checkbox"/> yes <input type="checkbox"/> no | venereal disease | <input type="checkbox"/> yes <input type="checkbox"/> no |

I hereby certify that I have read and understand the above questions and that the information provided is accurate to the best of my knowledge. I will not hold Dr. Gen or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes to this history later, I will so inform this practice.

I also consent to the making of diagnostic records, including x-rays, before, during and following orthodontic treatment.

Parent's signature: _____ Date _____ Doctor's signature: _____ Date _____