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Patient Information & Medical History - Child

Today's Date:_______________

Patient Name:_______________ Birthday:_______________ Sex:_______________

Address:_______________ City:_______________ State:_______________ Zip:_______________

Phone: ( )_______________ Parent is: ❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Separated

Mother's Name:_______________ Father's Name:_______________

Patient Lives with: _______________

MD:_______________ Phone:_______________ Dentist:_______________ Phone:_______________

Financially Responsible Party:_______________ Relationship: _______________

Birthday:_______________ Home Phone: ( )_______________ Cell Phone: ( )_______________

Bus. Phone: ( ) _______________ Address: _______________ City:_______________

State:_______________ Zip:_______________ Employer:_______________ Position: _______________

Employed Since:_______________ Phone: ( )_______________ Ext:_______________

Name of Spouse: _______________ Birthday:_______________

Employer: _______________ Position: _______________ Phone: ( )_______________

Insurance Primary Carrier:_______________ Phone: ( )_______________

Policy #_______________ Insured's Name:_______________ I.D. #_______________

Secondary Carrier: _______________ Phone #: ( )_______________

Policy #_______________ Insured's Name:_______________ I.D. #_______________

Other Family Members Treated:_______________

Musical Instrument Played:_______________ Favorite Sports & Hobbies:_______________

In Case We Cannot Reach You / Person To Contact:_______________ Phone: ( )_______________

This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including. reasonable attorney's fees and costs of collection in the event of default. I further understand that if a payment becomes 45 days past due, a $5.00 late fee will be assessed on delinquent amounts from the date the payment was due. I hereby authorize the release of medical information if necessary, and payments from the above mentioned Insurance company to go directly to Dr. A. Paul Serrano. I also understand that I am responsible for any balance that my insurance company does not pay for. I am aware that when appropriate, this office requests credit history information.

_______________ Signature of Responsible Party

_______________ Date

For the following questions circle 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.

yes no dk/u Does patient follow directions?
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?

MEDICAL HISTORY

yes no dk/u Birth defects or hereditary problems?
yes no dk/u Bone fractures, any major accidents?
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 or been treated for a tumor?
yes no dk/u Stomach ulcer or hyperacidity?
yes no dk/u Polio, mononucleosis, tuberculosis,
yes no dk/u Problems of the immune system?
yes no dk/u Hepatitis, jaundice or liver problem?
yes no dk/u AIDS or HIV Positive?
yes no dk/u Sexually transmitted disease?
yes no dk/u Fainting spells, seizures, epilepsy or neurologic disease.
yes no dk/u Mental health or behavioral problems?
yes no dk/u Vision, hearing, tasting or speech difficulties?
yes no dk/u Loss of weight recently, poor appetite?
yes no dk./u Excessive bleeding, black and blue tendency, anemia or bleeding disorder?
yes no dk/u High or low blood pressure?
yes no dk/u Easily tired?

yes no dk/u Chest pain, shortness of breath or swelling ankles?

yes no dk/u Cardiovascular problems (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects or rheumatic heart?

yes no dk/u Skin disorder

yes no dk/u Does patient have a normal and good diet?

yes no dk/u Frequent headaches, colds or sore throats?

yes no dk/u Any history of speech problems?

yes no dk/u Eye, ear, nose, throat condition?

yes no dk/u Hayfever, asthma, sinus trouble, hives?

yes no dk/u Tonsil or adenoid conditions?

yes no dk/u Allergies?

yes no dk/u Drug reactions?

yes no dk/u Is patient taking medication, nutrient supplements or prescription medicine? Please name them.

____

yes no dk/u Any history of antibiotic pre-medication prior dental appointment?

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

yes no dk/u Operations?

yes no dk/u Hospitalized? For______________________

yes no dk/u Other physical problems or symptoms?

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

For _________________________________

Date of most recent physical exam?_________

DENTAL HISTORY

yes no dk/u Started teething early or late?

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

yes no dk/u Permanent or "extra" (supernumerary) teeth removed?

yes no dk/u Supernumerary (extra) or congenitally missing teeth?

yes no dk/u Chipped or otherwise injured permanent teeth?

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

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

yes no dk/u "Dead Teeth", root canals, mouth odor?

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

yes no dk/u Periodontal "Gum Problems"?

yes no dk/u Food impaction between teeth?

yes no dk/u "Gum Boils" frequent canker sores, cold sores?

yes no dk/u Is patient taking any forms of fluorids?

yes no dk/u Thumb, finger, sucking habit? Until ________

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

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

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

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

yes no dk/u Does the patient experience 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, palate?

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

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

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

yes no dk/u Any wisdom tooth problems?

yes no dk/u Has patient had any serious trouble associated with any previous dental treatment?

yes no dk/u Onset of puberty (approximate date)___________

yes no dk/u Has patient ever had a prior orthodontic examination or treatment?

yes no dk/u Has patient recently been under another dentist's care?

Specialist________________________________

Other____________________________________

yes no dk/u Has the patient ever had Periodontal (gum) treatment?

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

Date of most recent dental examination ________________________

How often does the patient brush ____________, Floss ____________

Father's Height _______________ Mother's Height_____________

Birth Weight__________ Present Weight___________ Height________

Number of Brothers and Sisters ______________________________

What is the patient's (or parent's) primary concern? – Why are you here?

____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment?

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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.

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Signature of parent or guardian Date

Medical History Update or Changes: Date: Comments: Signature

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