Seuss Orthodontics

Life Changing Smiles

CHILD HEALTH FORM

PATIENT INFORMATION

Patient's name _____ Birthdate___/__/___Age_____ Sex: F [ ] M [ ]
Home Address _____
City, State _____ Zip _____ How long at address _____
Home Phone _____ School _____Grade _____
Patient's hobbies _____
Parents' marital status _____ Custodial parent's name _____
Names and ages of other children in family _____
General Dentist _____ Physician _____
Who may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION (custodial parent only)

Name _____ Marital status _____
Home Address _____ Own [ ] Rent [ ]
City, State _____ Zip _____ How long at address _____
Previous Address (if less than 3 years) _____
Home Phone _____ Work Phone _____ Cell phone _____
Social Security # _____ Birthdate _____/_____/_____ Relationship to patient _____
Employer _____ Occupation _____ No. years employed _____
Responsible Party Email: _____
Spouse's Name _____ Birthdate_____/_____/_____
Relationship to patient _____ Cell Phone _____
Social Security # _____ Employer _____
Work Phone _____ Occupation _____ No. years employed _____

DENTAL INSURANCE INFORMATION

Insured's Name _____DOB _____ SS/ID # _____
Insured's Address_____
Signature of Insured for Benefits_____ Relationship to patient_____
Employer_____ Group #_____
Insurance Company _____ Phone # _____
Do you have dual coverage? **YES [ ]** **NO [ ]**
Insured's Name _____DOB _____ SS/ID # _____
Insured's Address_____
Signature of Insured for Benefits_____ Relationship to patient_____
Employer_____ Group #_____
Insurance Company _____ Phone #_____

EMERGENCY INFORMATION

Name of nearest **relative not living with you** _____ (relationship) _____
Address _____ Home phone _____
City, State _____ Zip _____ Work phone _____
I understand the information I have given is correct and I authorize the dental team to perform the necessary dental services my child may need. I understand where appropriate, credit bureau reports may be obtained.
Signature (parent/guardian if minor) _____ Date _____

Patient's Name_____

MEDICAL INFORMATION

Please check box if patient has or had any of the following:

Allergies - List: _____

Anemia	❑	Endocrine/Thyroid Problem	❑	HIV (tested positive)/AIDS	❑
Asthma	❑	Fainting	❑	Liver/Kidney Problem	❑
Blood Transfusion	❑	Fever Blisters/Herpes	❑	Nervous/Hyperactive	❑
Bone Disorder	❑	Frequent Headaches	❑	Prolonged Bleeding	❑
Cancer	❑	Glaucoma	❑	Rheumatic Fever	❑
Convulsions	❑	Handicaps/Disabilities	❑	Tobacco Use	❑
Emotional Problems	❑	Hearing Problems	❑	Tuberculosis	❑
Artificial Bones/Joints/Valves	❑	Heart Problems	❑	Venereal Disease	❑
				Removal of Tonsils/Adenoids	❑

Is Patient in good health? **YES / NO** Is Patient under a physician's care? **YES / NO**

If yes, for what reason _____

Are there any impending medical conditions? **YES / NO**

If yes, describe _____

Is Patient taking prescription medications? **YES / NO**

If yes, list _____

For children and adolescence only

Has puberty been reached? (start of menstruation or voice change) **YES / NO**

If yes, has it been within the last two years? **YES / NO**

DENTAL HISTORY

	YES	NO		YES	NO
Has Patient had a recent dental check-up?	❑	❑	Date _____		
Any missing teeth?	❑	❑	Any extra teeth?	❑	❑
Any night time clenching or grinding habit?	❑	❑	Clicking/locking or pain when opening jaws?	❑	❑
Any speech problems?	❑	❑	Surgery to repair cleft lip and/or cleft palate?	❑	❑
Frequent mouth breathing?(awake/sleeping)	❑	❑	Has Patient ever seen an orthodontist?	❑	❑
Does Patient snore or have difficulty breathing during sleep?	❑	❑	Has Patient ever sucked thumb or finger?	❑	❑

	YES	NO	
Have any primary/permanent teeth been removed by extraction?	❑	❑	
Has either parent had orthodontic treatment?	❑	❑	
Family history of short rooted teeth?	❑	❑	
Has Patient been diagnosed with tongue thrust?	❑	❑	
Family history of tongue thrust?	❑	❑	
Family history of tongue tied or high frenum attachments?	❑	❑	
Is Patient sensitive or self-conscious about his/her teeth?	❑	❑	
Is Patient adopted?	❑	❑	Does he/she know? **YES / NO**
Does Patient resemble mother and/or father? (please circle)	M	F	
Does anyone in family have similar dental conditions?	❑	❑	
Would Patient mind wearing braces?	❑	❑	
Has a dentist ever placed a retainer or space maintainer?	❑	❑	
Do you understand some appointments will need to be scheduled during work/school hours?	❑	❑	
Has your child been bullied due to his/her smile?	❑	❑	

How many soft drinks consumed daily_____ weekly _____

How many sport drinks consumed daily_____ weekly _____

What are the main concerns you would like orthodontics to accomplish?

_____