STURGILL ORTHODONTICS

CHILD HEALTH FORMS

ABOUT YOUR CHILD

NAME: _____

PREFERRED NAME: _____ ☐ MALE ☐ FEMALE

BIRTHDATE: ____/____/____ AGE: ___

HOME ADDRESS: _____

_____

SCHOOL: _____ GRADE: _____

HOBBIES/SPORTS: _____

MUSICAL INSTRUMENTS: _____

GENERAL INFORMATION

WHO IS ACCOMPANYING THIS CHILD TODAY?

NAME: _____

RELATION: _____ LEGAL GUARDIAN? ☐ YES ☐ NO

WHO IS FINANCIALLY RESPONSIBLE FOR THE ACCOUNT?

_____

WHO IS RESPONSIBLE FOR MAKING APPOINTMENTS?

_____

PARENTS' MARITAL STATUS:

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

CHILD'S MEDICAL HISTORY

PHYSICIAN'S NAME: _____

PHONE: (___)_____ LAST VISIT: _____

CHILD'S PHYSICAL HEALTH IS: ☐ GOOD ☐ FAIR ☐ POOR

HEIGHT: _____ WEIGHT: _____

IS YOUR CHILD CURRENTLY BEING TREATED BY A PHYSICIAN? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

HAS YOUR CHILD HAD ANY METAL RODS, PINS, OR IMPLANTS? ☐ YES ☐ NO

PLEASE LIST ANY PRESCRIPTIONS OR OVER THE COUNTER DRUGS YOUR CHILD TAKES AND THE REASON FOR MEDICATION:

_____

_____

HAS YOUR CHILD EVER TAKEN FOSAMAX, ACTONEL, BONIVA, OR ANY OTHER FORM OF BISPHOSPHATE? ☐ YES ☐ NO

ARE YOUR CHILD'S IMMUNIZATIONS CURRENT? ☐ YES ☐ NO

ANYTHING YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR IN PRIVATE? ☐ YES ☐ NO

FEMALES ONLY:

HAS SHE BEGUN MENSTRUATION? ☐ YES ☐ NO

DOES SHE TAKE BIRTH CONTROL? ☐ YES ☐ NO

IS SHE PREGNANT? ☐ YES ☐ NO

PARENTS INFORMATION

☐ FATHER ☐ STEP FATHER ☐ GUARDIAN ☐ OTHER: _____

NAME: _____

BIRTHDATE: ____/____/____ AGE: ___ SSN# _____

HOME ADDRESS: _____

_____

HOME: (___)_____ CELL: (___)_____

EMAIL: _____

PREFERRED CONTACT: ☐ HOME ☐ CELL ☐ WORK ☐ EMAIL ☐ TEXT

EMPLOYER: _____

HOW LONG THERE?: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____

_____

ORTHODONTIC BENEFIT? ☐ YES ☐ NO ☐ UNSURE

INSURANCE CO. NAME: _____

INSURANCE CO. PHONE NUMBER: (___)_____

GROUP POLICY NUMBER: _____

PARENTS INFORMATION

☐ MOTHER ☐ STEP MOTHER ☐ GUARDIAN ☐ OTHER: _____

NAME: _____

BIRTHDATE: ____/____/____ AGE: ___ SSN# _____

HOME ADDRESS: _____

_____

HOME: (___)_____ CELL: (___)_____

EMAIL: _____

PREFERRED CONTACT: ☐ HOME ☐ CELL ☐ WORK ☐ EMAIL ☐ TEXT

EMPLOYER: _____

HOW LONG THERE?: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____

_____

ORTHODONTIC BENEFIT? ☐ YES ☐ NO ☐ UNSURE

INSURANCE CO. NAME: _____

INSURANCE CO. PHONE NUMBER: (___)_____

GROUP POLICY NUMBER: _____

CHILD'S ALLERGIES

DOES YOUR CHILD HAVE ANY ALLERGIES? ☐ YES ☐ NO IF YES, PLEASE CIRCLE FROM THE LIST BELOW OR WRITE IN THE SPACE PROVIDED:

Aspirin Metals/Nickel Advil/Ibuprofen Penicillin Latex Codeine Dogs

OTHER ALLERGIES AND REACTIONS: _____

_____

_____

Has your child ever had any of the following? (please circle)

Y N ADD/ADHD
Y N Autism Spectrum/Asperger's
Y N AIDS/HIV
Y N Artificial Joints/Valves
Y N Asthma
Y N Bed Wetting
Y N Cancer
Y N Canker/Cold Sores
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Handicap/Disability
Y N Hay Fever
Y N Hearing Impairment
Y N Heart Surgery
Y N Heart Murmur
Y N Hemophilia/Blood Disorder
Y N Hepatitis
Y N Herpes/Fever Blisters
Y N Hospital Stay/Operations
Y N High Blood Pressure
Y N Large Tonsils
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Prosthetic
Y N Psychiatric Problems
Y N Rheumatic/Scarlet Fever
Y N Seizures/Convulsions
Y N Sickles Cell Disease/Trait
Y N Sinus Problems
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers

OTHER MEDICAL CONDITION(S): _____

_____

CHILD'S DENTAL HISTORY

LIST ANY CONCERNS YOU HAVE ABOUT YOUR CHILD'S SMILE AND/OR BITE:

_____

_____

PRIOR HISTORY OF ORTHODONTIC TREATMENT: _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

OTHER FAMILY MEMBERS SEEN BY US: _____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS? (PLEASE CIRCLE)

Y N Thumb/Finger Sucking Y N Lip Sucking/Biting Y N Nail Biting Y N Tongue Thrust

GENERAL/PEDIATRIC DENTIST: _____

LAST VISIT: _____ REASON FOR VISIT: _____

Has your child ever been evaluated by an orthodontist?	☐ YES	☐ NO	Does your child grind their teeth?	☐ YES	☐ NO
Does your child have any missing permanent teeth?	☐ YES	☐ NO	Has your child ever been treated for TMJ/TMD?	☐ YES	☐ NO
Does your child brush their teeth twice daily?	☐ YES	☐ NO	Does your child have pain in their jaw joints?	☐ YES	☐ NO
Family history of jaw surgery for bite correction?	☐ YES	☐ NO	Does your child's jaw routinely pop or click?	☐ YES	☐ NO
History of speech problems?	☐ YES	☐ NO	Has your child's jaw ever locked open or closed?	☐ YES	☐ NO
Does your child commonly snore?	☐ YES	☐ NO	Does your child experience pain in their ears?	☐ YES	☐ NO
History of major trauma/injury of the face, jaw, teeth, or mouth?	☐ YES	☐ NO	Have adenoids and/or tonsils been removed?	☐ YES	☐ NO
			Does your child typically breathe through their (circle one)	MOUTH	NOSE

I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to Sturgill Orthodontics. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including records of examination, diagnosis, and treatment rendered, to my insurance company. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent. I understand that Sturgill Orthodontics reserves the right to verify the credit status of patients and/or their parents prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services. Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, the ADA, and the AAO.

SIGNATURE: _____ DATE: _____

OFFICE USE ONLY

I HAVE VERBALLY REVIEWED THE MEDICAL/DENTAL INFORMATION WITH THE PATIENT NAMED HEREIN.

TC SIGNATURE: _____ DOCTOR SIGNATURE: _____