Str8rsmiles

Patient Health History Form

Today's Date: __________

Patient Name:____ Gender: ☐ Male ☐ Female

Last First MI

Birthdate:_____/____/______ Age: ________ SS#:________________ Home Phone: (____)________________

Patient Home Address:____

Street City ST Zip

School:_______________________________ Grade:________ Email:______________________________

Hobbies/ Sports:____

Who is accompanying your child today?

Name:____ Relation: ____________________

Do you have legal custody of this child? ☐Yes ☐No Whom may we thank for referring you?________________

Other family members seen by us?____

Parents Marital Status: ☐Single ☐Married ☐Partnered ☐Separated ☐Divorced ☐Widowed

Dentist Name: ________________________☐ Previous ☐ Present Date last cleaning/visit?_______________

Parental Information: ☐ Mother ☐ Stepmother ☐ Guardian

Name:____ Birthdate:______/______/__________

Work Phone:(___)________________ Home Phone:(___)________________ Mobile:(___)________________

Employer:____________________________ Job Title:__________________ How long at current job?_________

Social Security # :______________________________ Driver License# :_____________________________

☐ Father ☐ Stepfather ☐ Guardian

Name:____ Birthdate:______/______/__________

Work Phone:(___)________________ Home Phone:(___)________________ Mobile:(___)________________

Employer:____________________________ Job Title:__________________ How long at current job?_________

Social Security # :______________________________ Driver License# :_____________________________

Person Responsible for Account

Name:____ Relation to Patient:____________________

Billing Address:____

Street City ST Zip

Previous Address:____

Street City ST Zip

Home Phone:(___)________________ Work Phone:(___)________________ Mobile:(___)________________

Employer:____________________________ SS# :________________ Driver License#_____________________

Person Responsible for Making Appointments

Name:____ Relation to Patient:____________________

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Home Phone:(___)________________ Work Phone:(___)________________ Mobile:(___)________________

Primary Orthodontic Insurance: Orthodontic Coverage? □ Y □ N Dental Coverage? □ Y □ N

Insurance Company Name: ____

Insurance Company Address:____

Insurance Company Phone Number: (____)_____________________ Group/Plan/Policy #: ________________

Policy Owner's Name:_______________________________ Policy Owner's ID #:_________________________

Policy Owner's Birthdate: ______/______/_________ Relationship to Patient: _________________________

Policy Owner's Employer:_______________________ Employer Address: _______________________________

Secondary Orthodontic Insurance:

Insurance Company Name: ____

Insurance Company Address:____

Insurance Company Phone Number: (____)_____________________ Group/Plan/Policy #: ________________

Policy Owner's Name:_______________________________ Policy Owner's ID #:_________________________

Policy Owner's Birthdate: ______/______/_________ Relationship to Patient: _________________________

Policy Owner's Employer: ______________________ Employer Address: _______________________________

Payment is due in full at the time of treatment unless prior arrangements have been approved by our office.

If this office accepts insurance, I understand that I am responsible for payment of services and paying any co-payment that my insurance does not cover, including deductible. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information including the diagnosis and records of treatment or examination rendered, to my insurance company.

____

Parent/Guardian Signature Date

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Emergency Contact Information

Neighbor or Relative not living with you:

Name ____ Relationship ______________________________

Address:____

Street City State Zip

Medical History

Child's Physician: _____________________________ Phone #: (____)__________________________

Date of last visit: ______/_____/______ Your child's current health is: ☐ Good ☐ Fair ☐ Poor

Has puberty begun? ☐ Y ☐ N Girls - has menstruation begun? ☐ Y ☐ N

Please list all drugs your child is currently taking:____

Please list all drugs/things your child is allergic to: ____

Latex ☐ Y ☐ N Metals/Nickel ☐ Y ☐ N Plastics ☐ Y ☐ N

Has your child ever taken Phen-Fen (Redux or Pondimin)? ☐ Y ☐ N If so, when? _______________

Has your child ever been evaluated or had orthodontic treatment before? ☐ Y ☐ N

Have there been any injuries to the face, mouth, teeth or chin? ☐ Y ☐ N

Have adenoids or tonsils been removed? ☐ Y ☐ N

Has your child been informed of any missing or extra permanent teeth? ☐ Y ☐ N

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMF)? ☐ Y ☐ N

Does your child brush his/her teeth daily? ☐ Y ☐ N

Does your child floss his/her teeth daily? ☐ Y ☐ N

Is your child currently under the care of a physician? ☐ Y ☐ N

If yes, please explain:____

Has your child ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding/ Hemophilia
Y N ADD/ADHD
Y N Allergies to Any Drugs
Y N Allergic to Latex/Metals
Y N Allergic to Plastic
Y N Any Hospital Stays
Y N Any Operations
Y N Artificial Bones/ Joints/ Valves
Y N Asthma
Y N Cancer/ Chemotherapy
Y N Congenital Heart Defect
Y N Convulsions/Epilepsy
Y N Diabetes
Y N Disabilities/Handicaps
Y N Frequent Headaches
Y N Hearing Impaired
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N HIV+/AIDS
Y N Kidney/Liver Problems
Y N Lupus
Y N Rheumatic/ Scarlet Fever
Y N Tuberculosis (TB)

Please discuss any medical conditions that your child has had:____

Has your child ever experienced any of the following?

Y N Clenching/Grinding Teeth
Y N Lip Sucking/Biting
Y N Mouth Breather
Y N Nail Biter
Y N Nursing/Bottle Habits
Y N Speech Problems
Y N Thumb/Finger Sucking
Y N Tongue Thrust

Aberdeen
1010 Beards Hill Rd Suite G
410-272-7970

Edgewood
1401 Pulaski Highway Suite V
410-679-2523

Elkridge
8182 Lark Brown Rd
410- 799-8194

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Our Office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

Parent/Guardian Signature:____

Doctor Signature:____

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 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. This office reserves the right to verify the credit of potential patients and/or patients 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.

____

Signature Date

Office Use Only

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Doctor's Comments: ____

____

____

Initials: ____________________ Date: _____________________

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