

Str8rsmiles

Patient Health History Form

Today's Date: _____

Patient Name: _____ Gender: Male Female

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: _____

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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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 Diabetes

Y N ADD/ADHD

Y N Disabilities/Handicaps

Y N Allergies to Any Drugs

Y N Frequent Headaches

Y N Allergic to Latex/Metals

Y N Hearing Impaired

Y N Allergic to Plastic

Y N Heart Murmur

Y N Any Hospital Stays

Y N Hemophilia

Y N Any Operations

Y N Hepatitis

Y N Artificial Bones/ Joints/ Valves

Y N HIV+/AIDS

Y N Asthma

Y N Kidney/Liver Problems

Y N Cancer/ Chemotherapy

Y N Lupus

Y N Congenital Heart Defect

Y N Rheumatic/ Scarlet Fever

Y N Convulsions/Epilepsy

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 Nail Biter

Y N Thumb/Finger Sucking

Y N Lip Sucking/Biting

Y N Nursing/Bottle Habits

Y N Tongue Thrust

Y N Mouth Breather

Y N Speech Problems

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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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