Child Health History

Brian J Kim DDS MSD
Specialist in Orthodontics

Date _____

Confidential Responsible Party Information

A B C

Name _____ (LAST / FIRST / MIDDLE) Marital Status _____

Residence _____ (STREET / CITY / STATE / ZIP) ◇ **Own** ◇ **Rent**

Mailing Address _____ (STREET / CITY / STATE / ZIP)

How long at this address _____ Phone _____ (HOME) _____ (WORK) _____ (CELL) E-mail _____

Previous Address (if less than 3 yrs.) _____ (STREET / CITY / STATE / ZIP)

Social Security # _____ **Birthdate** _____ Relationship to Patient _____

Employer _____ **Occupation** _____ **No. Years Employed** _____

Spouse's Name _____ (LAST / FIRST / MIDDLE) Relationship to Patient _____

Social Security # _____ **Birthdate** _____ Phone _____ (WORK) _____ (CELL)

Employer _____ **Occupation** _____ **No. Years Employed** _____

Confidential Patient Information

Patient's Name _____ (LAST / FIRST / MIDDLE) ◇ Male ◇ Female

Patient's Address _____ (STREET / CITY / STATE / ZIP)

Phone _____ (HOME) _____ (CELL) E-mail _____ Birthdate _____ Social Security # _____

Child's Dentist _____ Child's Physician _____

If patient is a minor, give parent's or guardian's name _____

Please list any sports your child participates in, hobbies, interests or musical instruments he/she plays _____

Please list any family members who have received orthodontic treatment in our office _____

Whom may we thank for referring you to our office? _____

Dental & Orthodontic Insurance Information

Policy Holder's Name _____ Insurance Company _____

Insurance Company's Address _____ Phone _____

Group Number _____ Union Local Number _____ Social Security # _____

Policy Holder's Employer _____

Do you have dual coverage? ◇ Yes ◇ No *(If yes, please complete below.)*

Policy Holder's Name _____ Insurance Company _____

Insurance Company's Address _____ Phone _____

Group Number _____ Union Local Number _____ Social Security # _____

Policy Holder's Employer _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

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Medical History

Is your child in good health? ◇ Yes ◇ No

Does your child have any history of major illness? ◇ Yes ◇ No

Has your child ever been treated for an illness? ◇ Yes ◇ No

Has your child ever been afflicted with a heart ailment? ◇ Yes ◇ No

If so, please specify _____

Has your child been treated for any of the following :

◇Yes ◇No Diabetes
◇Yes ◇No Pneumonia
◇Yes ◇No Heart murmur
◇Yes ◇No Cardiovascular disease
◇Yes ◇No Rheumatic fever
◇Yes ◇No Bone disorder
◇Yes ◇No Herpes
◇Yes ◇No Anemia/radiation therapy
◇Yes ◇No Epilepsy
◇Yes ◇No Asthma
◇Yes ◇No Abnormal bleeding
◇Yes ◇No Convulsions/epilepsy
◇Yes ◇No Hearing impairment
◇Yes ◇No Tuberculosis
◇Yes ◇No Other _____

◇Yes ◇No Kidney/liver problems
◇Yes ◇No Tuberculosis
◇Yes ◇No AIDS/HIV+
◇Yes ◇No Hepatitis
◇Yes ◇No High/low blood pressure
◇Yes ◇No Prolonged bleeding
◇Yes ◇No Fainting/dizziness
◇Yes ◇No Nervous disorders
◇Yes ◇No Operations/surgery
◇Yes ◇No Endocrine problems
◇Yes ◇No Rheumatic/scarlet fever
◇Yes ◇No Severe/frequent headaches
◇Yes ◇No Artificial Implants
◇Heart Valve
◇Joints
◇Other Prosthesis

Is your child prone to any of the following:

◇Yes ◇No Colds
◇Yes ◇No Sore throats
◇Yes ◇No Ear infections

Have the tonsils/adenoids been removed? ◇ Yes ◇ No
If so, at what age? _____

Is your child currently taking any drugs/medications? ◇ Yes ◇ No
If so, please specify _____

Does your child have an allergy to any drugs, metal, food, and/or latex? ◇ Yes ◇ No
If so, please specify _____

Has your child reached puberty? ◇ Yes ◇ No

Height _____ Weight _____

Has your child ever taken fen-phen or redux? ◇ Yes ◇ No

Has your child ever taken oral and/or intravenous bisphosphonates (i.e., Fosamax, Boniva, etc.)? ◇ Yes ◇ No

Dental History

Child's current oral hygiene is: ◇ Good ◇ Fair ◇ Poor

Have there been any injuries to your child's face/mouth/teeth? ◇ Yes ◇ No

Has your child ever sucked his/her thumb/fingers? ◇ Yes ◇ No
Until what age? _____

Does your child have any speech problems? ◇ Yes ◇ No

Is your child a mouth-breather? ◇ Yes ◇ No
While awake? ◇ Yes ◇ No
While asleep? ◇ Yes ◇ No

Does your child have any habits affecting teeth? ◇ Yes ◇ No

Does your child have any missing teeth? ◇ Yes ◇ No

Does your child have any extra permanent teeth? ◇ Yes ◇ No

Has your child ever experienced any unfavorable reactions from any previous dental treatment? ◇ Yes ◇ No

Has an orthodontist been consulted? ◇ Yes ◇ No

Reason for consultation _____

Females Only

Are you taking birth control pills? ◇ Yes ◇ No

Are you pregnant? ◇ Yes ◇ No
Week#_____

Are you nursing? ◇ Yes ◇ No

Emergency Information

Name of nearest relative not living with you _____

Relationship _____

Home phone _____

Work phone _____

Update

Date	Change	Initials

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. 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 to this history record or medical/dental status.

Parent/guardian signature _____ Date _____

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