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CHILD PATIENT INFORMATION

Child's Name:____ Prefer to be called:____________________ Sex:________
First Last

Address: ____ City:_______________ State:_________ Zip:___________

Home Ph: ___________________ Parent E-Mail:________________________________ Birth date: ______________ Age:_______

School: __________________________________ Grade: _____ Sports/Hobbies: ____

Father's Name: _________________________________ Employer: ____________________ Work or Cell #: _______________
First Last
Employer Address: ____

Mother's Name: _________________________________ Employer: ____________________ Work or Cell #: _______________
First Last
Employer Address: ____

Parent's Marital Status: Single Married Divorced Separated Widow(er)

Number of children in family:________ Birth dates/Name: (/ / :); (/ / :); (/ / :)

Patient's Height: _________________ Mother's Height: ___________________ Father's Height: ______________________

Who will be responsible for the payment of this account?____

Have dental insurance with Ortho. coverage? _______ Insured/Subscriber Parent _________________ Insurance Co._______________

Group #: _________________ Soc. Sec or ID# of Insured: ________________________ Birth date of Insured: _____________

Whom may we thank for referring you? ____

Please describe your orthodontic concerns____

____

If we could wave a magic wand and change one thing about your child's smile, what would it be?___________________________

DENTAL HISTORY

General Dentist: _______________________ Address: ________________________________ Phone:__________________
(Circle appropriate information)
Frequency of dental checkups: Twice a year / Once a year / Only if a problem arises / Never ---Date of last cleaning:_____________

Is there any unfinished care to be completed with your child's dentist? No Yes Explain: ___________________________
Do you need to be premedicated for dental visits? No Yes Explain: ___________________________
Have teeth (either baby or permanent) been removed? No Yes Explain: ___________________________
Has your child had any face or dental injuries? No Yes Explain: ___________________________
Is there any history of thumb or finger sucking? No Yes Explain: ___________________________
Does your child play a musical instrument? No Yes Explain: ___________________________
Has your child consulted an orthodontist previously? No Yes Explain: ___________________________
Does the patient desire orthodontic treatment? No Yes Explain: ___________________________
Please circle if there is a history of:
Clenching teeth Jaw joint clicking Jaw joint soreness Jaw joint popping Grinding teeth Ringing in the ears
Headaches (more than normal) Muscular soreness around head & neck Bleaching Your Teeth – Date:________________
Speech problems (if so, which sounds) __________________________________ Mouth breathing while: Awake Asleep
Is there any other information that may be helpful? ____

Please Turn Over

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing for your dental care. All information will be kept completely confidential.

MEDICAL HISTORY

Child's Physician: ____ Last Visit: ________________________________

Address: ____ Phone: _______________________________

Is child in good health?	No	Yes	Explain:______________________________________
Serious illness or hospitalization?	No	Yes	Explain:______________________________________
Child taking any drugs or medication?	No	Yes	Explain:______________________________________
Is there an allergy to penicillin or other drugs?	No	Yes	Explain:______________________________________
Is there an allergy to Latex?	No	Yes	Explain:______________________________________
Rheumatic fever, heart disease, murmur?	No	Yes	Explain:______________________________________
Tonsils and/or adenoids removed?	No	Yes	Explain:______________________________________
Any learning disorders or emotional problems?	No	Yes	Explain:______________________________________
Is the patient sensitive, self-conscious?	No	Yes	Explain:______________________________________
Mental health or behavioral problems?	No	Yes	Explain:______________________________________
Birth defects or hereditary problems?	No	Yes	Explain:______________________________________
Bone fractures or major accidents?	No	Yes	Explain:______________________________________
Fainting spells, seizures, neurologic problems?	No	Yes	Explain:______________________________________
Under treatment of another professional?	No	Yes	Explain:______________________________________
If female, has menstruation begun?	No	Yes	At what age?__________________________________
If yes, could the patient be pregnant?	No	Yes	# of months: __________________________________
Does the patient smoke?	No	Yes	How much: ____________________________________
Has your child <u>ever</u> taken Bisphosphonate drugs? (Examples of Bisphosphonates = Fosamax, Didronel, Boniva)	No	Yes	When?________Why?___________________________

Any other health problems or special concerns:____

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Comments:____

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INSURANCE: To avoid misunderstandings regarding dental insurance, all professional services rendered are charged directly to the patient and the patient, parent and/or guardian are responsible for payment of fees. We will prepare necessary forms or reports to help you obtain benefits from your insurance company. In order to do so, please sign below authorizing Dr. McDonough's office to provide each respective insurance company, claim administrator and consulting health care professional information concerning health care, advice, treatment, or supplies provided. This form also authorizes release of any information relating to a claim submitted on your behalf. This information will be used exclusively for the purpose of evaluating and administering claims for benefits.

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one of more credit reporting services.

I have read and understand the above questions. If there are any changes later to this history record or medical/dental status I will inform this practice.

Print name of Authorized Guardian completing form:____

Signature of Authorized Guardian: ____ Date:__________

For Future Use

Medical History Update: Changes since last history: ____

____

Signature: ____ Date: ______________________________