

YOUTH HEALTH HISTORY

Date: ___/___/___
MM DD YYYY



PATIENT INFORMATION

Male / Female Birthdate: ___/___/___ Age: _____

First Name: _____ Initial _____ Last Name: _____

Preferred Name: _____ Cell: (_____) _____ Home: (_____) _____

Address: _____ **Dentist Name:** _____

Street City/State Zip

Patient's School: _____

Whom may we thank for referring you? Circle One: *Dentist* *Family* *Friend (Name)* _____

Google Website Co-Worker Location School Neighbor Marketing Other: _____

PARENT(S) INFORMATION: (MARITAL STATUS:) *Single* *Married* *Partnered* *Divorced* *Separated* *Widowed*

Mom Name: _____ **Cell:** (_____) _____ **Occupation:** _____

Dad Name: _____ **Cell:** (_____) _____ **Occupation:** _____

PERSON FINANCIALLY RESPONSIBLE

Circle One: * *Father* * *Mother* * *Stepmom* * *Stepdad* * *Grandparent* * *Guardian* * *Other*

Name: _____ Email: _____

Cell: (_____) _____ **Same address as above:** _____ (check if yes)

Work: (_____) _____ **Address:** _____
Street City/State Zip

DENTAL/ORTHODONTIC INSURANCE

PRIMARY

Dental Insurance Company: _____ SSN or ID# _____

Card Holder Name: _____ Card holder Birthdate: ___/___/___

Address (if different then above): _____
Street City/State Zip

Employer Name: _____

(Circle One:) *Father* *Mother* *Stepfather* *Stepmother* *Guardian* *Other:* _____

Dual Dental Insurance Coverage? **Yes** **No** **If yes, fill out secondary information below...**

SECONDARY

Dental Insurance Company: _____ SSN or ID# _____

Card Holder Name: _____ Card holder Birthdate: ___/___/___

Address (if different then above): _____
Street City/State Zip

Employer Name: _____

(Circle One:) *Father* *Mother* *Stepfather* *Stepmother* *Guardian* *Other:* _____

YOUTH HEALTH HISTORY

Patient Name: _____



PATIENT HEALTH HISTORY

Medical History: Check all that apply...

- ADHD
- Seizures/Epilepsy
- Heart Murmur/Congenital Heart Defect/Pre-Med Needed
- Diabetes
- Hepatitis or Liver Problems
- Prolonged Bleeding/Hemophilia
- Operations/stays in hospital...(List below)
- Currently Pregnant
- HIV + or AIDS
- Bisphosphonate Medication
- Autistic/Asperger's syndrom (circle)

Dental History: Check all that apply...

- Thumb/finger/lip sucking habits (circle) Continued Discontinued
- Pain, popping or locking when opening/closing jaw (circle)
- Have muscle tenderness or stiffness in jaw or neck? (circle)
- Had previous treatment for TMJ or jaw joint problems?
- Clinching/Grinding of teeth? (circle) DAY - NIGHT - BOTH
- Any injuries to face, mouth, teeth or chin? (circle)
- Been evaluated for orthodontic treatment (Second opinion)
- Had previous orthodontic treatment. When? _____
- Any known missing or extra permanent teeth?

CONCERNS: _____

MEDICATIONS: _____

Other Medical Conditions/Surgeries: _____

Allergies: (circle) Latex Metal Nickel Other: _____

PRIVACY CONSENT: (HIPPA)

Please list the individuals we are allowed to disclose financial and treatment information regarding the patient above.

Name:

Relationship to Patient:

I understand that the information I have given is correct to the best of my knowledge, and it will be held in the strictest confidence. I understand it is my responsibility to inform this office of any changes in my child's medical/dental status. I have read the notice of privacy practices. I authorize the orthodontic staff to perform the necessary dental services (including x-rays) of my child may need. I understand that if I take an x-ray performed at Smile Orthodontics to another orthodontic office that I will be charged. I understand that all original documents will be stored electronically. I understand that pictures of my child's teeth may be used for educational purposes. If this office accepts the assignment of benefit for my insurance, I understand that I am responsible for the payment of services rendered and responsible and responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature _____ **Date:** ____ / ____ / ____
MM DD YYYY