RUSTY JONES, DDS
Orthodontics

CHILD HEALTH HISTORY FORM

Date:_____

PATIENT INFORMATION

Child's Name_____Child's DOB_____Age_____
Last First Middle
Name Child prefers to be called_____
Child's Home Address_____City_____State_____Zip_____
Child's Home Phone Number_____
Child's School Name_____Grade_____
Parent's E-Mail (used for appointment reminders, kept confidential)_____
Sports/Hobbies_____Musical Instrument Played_____
Names and Ages of Other Family Members_____
Names of Other Family Members Treated in this Office_____
*Who may we thank for referring you to our Office?*_____
*Who is accompanying this child today?*_____
Your Name_____Your relationship to Child_____
(Natural Parent Yes No) (Child Adopted Yes No) (Foster Parent Yes No) Other-Specify_____

PARENT INFORMATION

MOTHER

Mother's Marital Status Married Divorced Widow Single Remarried
Choose: Mother Stepmother Guardian
Name_____Address_____City_____State_____Zip_____
Home Phone_____Work Phone_____Employer_____
Cell Phone_____Email Address_____

FATHER

Father's Marital Status Married Divorced Widow Single Remarried
Choose: Father Stepfather Guardian
Name_____Address_____City_____State_____Zip_____
Home Phone_____Work Phone_____Employer_____
Cell Phone_____Email Address_____

PERSON RESPONSIBLE FOR THIS ACCOUNT

Name_____Address_____City_____State_____Zip_____
SS#_____Daytime Phone_____Evening Phone_____

INSURANCE INFORMATION

Primary Insurance Information Relationship to Patient_____
Insured's Name_____Insured's DOB_____Insured SS#_____
Employer's Name_____Employer's Ph #_____
Employer's Address_____City_____State_____Zip_____
Insurance Company_____City_____State_____Zip_____
Insurance Ph #_____Name of Dental Plan_____

Secondary Insurance Information Relationship to Patient_____
Insured's Name_____Insured's DOB_____Insured SS#_____
Employer's Name_____Employer's Ph #_____
Employer's Address_____City_____State_____Zip_____
Insurance Company_____City_____State_____Zip_____
Insurance Ph #_____Name of Dental Plan_____

CONTINUED ON OPPOSITE SIDE

Reviewed with patient by_____Date_____

MEDICAL HISTORY

Physician_____Date of Last Visit_____
Physician's Address_____City_____State_____Zip_____

Please Circle Yes or No (If Yes, please fill in the details)

Yes No Are you taking any medication?_____
Yes No Are you allergic to any medication?_____
Yes No Are you presently under care of a physician_____Do you have a history of a major illness?_____
Yes No Have you ever had any major operation?_____ Yes No Ever been hospitalized?_____
Yes No Have you had your tonsils or adenoids removed?_____
Yes No Have you had any of the following: Asthma_____Allergies_____Hayfever_____Throat Infections_____
Yes No Are you allergic to anything? If yes please describe_____

Please circle the appropriate answer for the medical conditions below:

Yes No	**Abnormal Bleeding**	**Yes No**	**Endocrine Problems**	**Yes No**	**Liver Disease**
Yes No	**Tuberculosis**	**Yes No**	**Anemia**	**Yes No**	**Elipesy**
Yes No	**Lung/Respiratory**	**Yes No**	**AIDS**	**Yes No**	**Arthritis**
Yes No	**Glaucoma**	**Yes No**	**HIV+**	**Yes No**	**Blood Disorder**
Yes No	**Heart Murmur**	**Yes No**	**Nervous Disorders**	**Yes No**	**Contact Lenses**
Yes No	**Bone/Joint Disorders**	**Yes No**	**Heart Problems**	**Yes No**	**Pneumonia**
Yes No	**Cancer/Tumor**	**Yes No**	**Hepatitis-Type_____**	**Yes No**	**Prolonged Bleeding**
Yes No	**Diabetes**	**Yes No**	**Herpes**	**Yes No**	**Hyperactive**
Yes No	**High Blood Pressure**	**Yes No**	**Rheumatic Heart**	**Yes No**	**Thyroid Disease**
Yes No	**Dizziness/Fainting**	**Yes No**	**Emotional Problems**	**Yes No**	**Sinusitis**
Yes No	**Kidney Involvement**				

DENTAL HISTORY

Dentist_____Date of Last Visit_____
Dentist's Address_____City_____State_____Zip_____Phone #_____
What concerns you most about your teeth?_____
Does the patient want teeth straightened?_____

Please circle the appropriate answer to the following questions, and explain if needed:

Yes No Have there ever been any injuries to the face, mouth or teeth?_____
Yes No Have you ever been informed of missing, extra or chipped teeth?_____
Yes No Have you ever had any abscessed teeth?_____
Yes No Is any of your mouth sensitive to temperature or pressure?_____
Yes No Do your gums bleed when you brush your teeth?_____
Yes No Do you have any type of thumb or tongue habit?_____
Yes No Have you ever had any speech therapy?_____
Yes No Do you have TMJ?_____
Yes No Are you aware of your jaw clicking or popping?_____
Yes No Have you ever been told that you grind your teeth?_____
Yes No Are you aware of clenching your teeth?_____
Yes No Do you have "tension" headaches?_____
Yes No Do you have "frequent" headaches?_____
Yes No Do you brush your teeth daily? How many times?_____
Yes No Do you floss your teeth daily?_____

BENEFITS OF ORTHODONTICS
Aesthetics, Health and Function

Orthodontics is a service that provides an improvement in the appearance of the teeth and in the general function of the teeth, and general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout lifetime, and there can be some movement of the teeth, and some change after treatment. I hereby state that I have read and understand the above paragraph, and that I have truthfully to the best of my ability answered all the above questions.

Patient/Parent Signature_____Date_____

OFFICE USE

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

Doctor's comments:

_____
_____