Child Health History Form

About Your Child

Today's Date _____

Name _____ Preferred Name/Nickname _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Birth Date _____ Age ____ Sex M / F School _____

Parents or Guardians

Patient Lives with: Both Parents Together / Both Parents Separately / Mother / Father / Other

Mother / Guardian _____Employer _____ Cell Phone_____

Father / Guardian _____Employer _____ Cell Phone_____

Parent's Address (if different from patient's) _____City _____

State _____ Zip _____ Email Address _____

How did you hear about our office? _____

What is the reason your child is seeking an orthodontic evaluation? _____

_____

Has an orthodontist been consulted previously? Y / N Reason _____

Please list other family members seen in our office and their relationship to this patient

_____

Medical Health Information

Is the patient adopted? Y / N at what age? _____

Name of your child's physician _____ Phone _____

Do your child have or had any of the following disease or conditions (circle those that apply)

Diabetes	Fainting Spells Seizures	AIDS, HIV Positive
Stroke	Scarlet Fever, Rheumatic Heart Diseases	Herpes, Fevers Blisters
Asthma	Allergies (medicine or other)	Joint Replacement or Implant
Hepatitis	Latex or Nickel Sensitivity/Allergy	Excessive Bleeding or Bruising
Tonsillitis	High or Low Blood Pressure	Drug or Alcohol Dependency
Pregnancy	Tonsils/Adenoids Removed	Heart Defect, Murmur,Disease

Does this patient now or has he/she ever taken bisphosphonates, including Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, or Zometa? Y / N If so, which drug? _____

If Female, has she begun menstruating? Y / N

Has your child been hospitalized for any surgical procedure of serious illness? Y / N

Does your child have any disease, condition, or problem not listed that you think we should know about? Please Explain: _____

Is your child taking any medication at this time? Y / N Please list

_____

Dental Insurance Information

Primary Insurance Company Name _____

Address _____ Group/Plan Number _____

Primary Policy Holder Name _____ SSN _____ Date of Birth _____

Secondary Insurance Company Name _____

Address _____ Group/Plan Number _____

Secondary Policy Holder Name _____ SSN _____ Date of Birth _____

Do you participate in a flex plane? Y / N

Dental Health Information

Is your child experiencing any dental problems? Y / N Date of last dental visit _____

How often does your child brush and floss each day? Brush ____ per day Floss _____ per day

Dentist _____ Phone _____

Does your child have or has he/she had any of the following disease or problems? (circle those that apply)

Tongue Thrust	Jaw Pain(Joint, Ear, Side of Face)	Extra Adult Teeth
Sore or Bleeding Gums	Tooth Sensitivity (Heat, Cold Sweets)	Fear of Dental Work
Permanent Tooth Extraction	Previous Orthodontic Treatment	Clenching of Grinding
Difficulty Chewing	Head/Neck, Jaw or Tooth Injury	Finger or Lip Habit
Missing Permanent Teeth	Clicking or Popping of the Jaw Joints	

Personal Information

Does the patient have any siblings? Y / N If yes, what are their ages? _____

Please list any special interests of the patient (sports, hobbies, etc) _____

Patient's attitude toward orthodontic treatment (circle one)

Very Motivated Will Cooperate(if needed) Not Motivated

Photo Release

I hereby consent to and authorize the use and reproduction, in print or electronic format by Valley Smiles Orthodontics, of any and all photographs which have been taken for any marketing and advertising purposes, without compensation. All images are owned by Valley Smiles Orthodontics. Accept / Decline

I acknowledge that the above information is correct. I will notify Dr. Lee of any changes that occur after this date. I hereby authorize Dr. Lee and his team to perform an initial orthodontic evaluation/examination.

Guardian Signature _____ Date _____