TRAN ORTHODONTICS

— SPECIALIST IN BRACES —

Child Patient Health History Form

Today's Date: ______/______/________

Patient Information

Patient's Name: ________________________________ Nick Name: ______________
First Last Middle Initial

Home Address: ________________________________
Street Apt./Condo #

____
City State Zip Code

Home Number: ______________ Sex: ☐ Male ☐ Female D.O.B. ____/____/_____ Age: __________

School: ______________________ Grade: ______________
Whom may we thank for reffering you? ______________________
List Brothers / Sisters with age: ______________________
General Dentist: ______________ Last Visit: __________ Contact Number: ____________

Who is Accompanying The Child Today?

Name: ______________________ Relationship: ______________
Do you have legal custody of this child? ☐ Yes ☐ No

Parent's Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partnered

Mother's Information: Name: ______________________
D.O.B. ____/____/_____ SSN: ______________ ☐ Guardian ☐ Step Mother
Cell Number: ______________ Home Number: ______________
Work Number: ______________ Ext: _______ Email: ______________
Employer: ______________________ Job Title: ______________

Father's Information: Name: ______________________
D.O.B. ____/____/_____ SSN: ______________ ☐ Guardian ☐ Step Father
Cell Number: ______________ Home Number: ______________
Work Number: ______________ Ext: _______ Email: ______________
Employer: ______________________ Job Title: ______________

Person Responsible for Account

Name: ______________________ ☐ Same as Above

Billing Address: ________________________________ D.O.B. _____/_____/_____
Street Apt./Condo #

________________________________ SSN: ______________
City State Zip Code
Employer: ______________________ Relationship: ______________

Home Number: ______________ Work Number: ______________ Ext: _______

Emergency Information

His/her Name: ______________________ Relationship: ______________

Home Number: ______________________ Work Number: ______________

Orthodontic Insurance

Orthodontic Coverage: ☐ Yes ☐ No Dental Coverage: ☐ Yes ☐ No

Insurance Company Name: ____________________

Insurance Company Address: ____________________
Street

____
City State Zip Code

Insurance Company Phone Number: ____________________ Group Number ____________________

Insured's Name: ____________________ Relationship: ____________________

Insured's Birthdate: ______/______/______ Insured's SSN: ____________________

Insured's Employer: ____________________

Medical History

Have you every had any of the following problems?

☐ Yes ☐ No	Abnormal Bleeding		☐ Yes ☐ No	Diabetes
☐ Yes ☐ No	ADD / ADHD		☐ Yes ☐ No	Handicaps / Disabilities
☐ Yes ☐ No	Allergies to any Drugs		☐ Yes ☐ No	Hearing Impairment
☐ Yes ☐ No	Allergic to Latex / Metals		☐ Yes ☐ No	Heart Murmur
☐ Yes ☐ No	Allergic to Plastic		☐ Yes ☐ No	Hemophilia
☐ Yes ☐ No	Any Hospital Stays		☐ Yes ☐ No	Hepatitis
☐ Yes ☐ No	Any Operations		☐ Yes ☐ No	HIV+ / AIDS
☐ Yes ☐ No	Any Artificial Bones / Joints/ Valves		☐ Yes ☐ No	Kidney / Liver Problems
☐ Yes ☐ No	Asthma		☐ Yes ☐ No	Lupus
☐ Yes ☐ No	Cancer		☐ Yes ☐ No	Rheumatic / Scarlet Fever
☐ Yes ☐ No	Congenital Heart Defect		☐ Yes ☐ No	Tuberculosis
☐ Yes ☐ No	Convulsions / Epilepsy		☐ Yes ☐ No	Other : ____________

Dental History

What are the main concerns that you would like orthodontics to accomplish?

____

____

Has your child ever taken Phen-Fen? ☐ Yes ☐ No If Yes, when? ____________________

Has your child ever been evaluated or had orthodonic treatment before? ☐ Yes ☐ No

Have there been any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No

Does your child play any musical instruments? ☐ Yes ☐ No If Yes, list instruments played: ____________________

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Has your child been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Has your child ever had any pain / tenderness in his /her jaw joint (TMJ /TMD)? ☐ Yes ☐ No

Does your child brush his / her teeth daily ☐ Yes ☐ No Floss his or teeth daily? ☐ Yes ☐ No

Child's Physician: ____________________

Phone Number: ____________________ Last Visit: ____________________

Is your child currently under the care of a physician? ☐ Yes ☐ No

Has puberty begun? ☐ Yes ☐ No Has Menstruation begun? (Girls) ☐ Yes ☐ No

Please describe your child's current physical health: ☐ Good ☐ Fair ☐ Poor

Please list all drugs that your child is currently taking: ____________________

Please list all drugs that your child is allergic to: ____________________

Latex ☐ Yes ☐ No Metals / Nickel ☐ Yes ☐ No Plastic ☐ Yes ☐ No

I understand that the information I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informal consent. I understand that if the office accept my insurance that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

____

Signature Date