Child Patient Health Record

C

Date _____ Nickname _____

Name _____ Date of Birth _____ Age _____

☐ Male ☐ Female Height _____ Weight _____ School _____ Grade _____

Home Phone ( ) _____ Email _____

Home Address _____
Street Apt # City State / Zip

Parent Information

Who is Accompanying the Child Today? _____ Do You Have Legal Custody of This Child? ☐ Yes ☐ No
Name Relation

Other Siblings _____

General Dentist _____ ( ) _____ Last Visit Date _____
Name Phone

Emergency Contact _____ ( ) _____
Name Phone

_____
Street Address Apt # City State / Zip

Who is Responsible for Account? _____ Parent Marital Status ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

Father

_____ / / _____
Name Date of Birth

Street Address (if Different than Child's) _____

( ) _____ Ext ( ) _____
Work Phone Home Phone

Email ( ) _____
Cell / Other

Employer _____ Occupation _____

Street Address _____ City _____ State / Zip _____

If you have Orthodontic Insurance Coverage for the Child, please fill out below:

Drivers License # _____ Social Security # _____

Insurance Co. Name _____ Group # (Plan, Local or Policy) _____

Phone _____ ID# _____

Street Address _____ City _____ State / Zip _____

Mother

_____ / / _____
Name Date of Birth

Street Address (if Different than Child's) _____

( ) _____ Ext ( ) _____
Work Phone Home Phone

Email ( ) _____
Cell / Other

Employer _____ Occupation _____

Street Address _____ City _____ State / Zip _____

If you have Orthodontic Insurance Coverage for the Child, please fill out below:

Drivers License # _____ Social Security # _____

Insurance Co. Name _____ Group # (Plan, Local or Policy) _____

Phone _____ ID# _____

Street Address _____ City _____ State / Zip _____

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize the release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

X _____
Signature of parent or guardian Date

What is Your Primary Concern? _____

Dental History Now or in the past, has the Patient had:

Yes	No	dk/u		Yes	No	dk/u	
☐	☐	☐	Started Teething Very Early or Very Late?	☐	☐	☐	Difficulty Encountered in Chewing or Jaw Opening?
☐	☐	☐	Permanent or "Extra" (Supernumerary) Teeth Removed?	☐	☐	☐	Concerned About Spaced, Crooked or Protruding Teeth?
☐	☐	☐	Chipped or Injured Primary (Baby) / Permanent Teeth?	☐	☐	☐	"Gum Boils", Frequent Canker Sores or Cold Sores?
☐	☐	☐	Jaw Fractures, Cysts or Mouth Infections?	☐	☐	☐	Taking Any Forms of Fluoride?
☐	☐	☐	Thumb, Finger or Sucking Habit? Until What Age?	☐	☐	☐	Any Relative with Similar Tooth or Jaw Relationships?
☐	☐	☐	Abnormal Swallowing Habit (Tongue Thrusting)?	☐	☐	☐	Ever Had a Prior Orthodontic Examination or Treatment?

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental/orthodontic services my child may need.

X _____
Signature of parent or guardian Date

Patient Profile

C

For the following questions mark **Yes**, **No** or **Don't Know/Understand (dk/u)**. The answers are for office records only and will be considered confidential.
A thorough and complete history is vital to a proper orthodontic evaluation.

Yes	No	dk/u	
☐	☐	☐	Does Patient Follow Directions Well?
☐	☐	☐	Does Patient Have Learning Disabilities or Need Extra Help with Instructions?
☐	☐	☐	Does Patient Brush His/Her Teeth Conscientiously?
☐	☐	☐	Is Patient Sensitive or Self-Conscious About Teeth?

Medical History

Now or in the past, has the Patient had:

Yes	No	dk/u	
☐	☐	☐	AIDS, ARC, HIV Positive or Other STD
☐	☐	☐	Allergies or Hives - Hay Fever, Asthma, Sinus Trouble
☐	☐	☐	Anemia, Excessive Bleeding or Bruising Tendency
☐	☐	☐	Anorexia or Bulimia
☐	☐	☐	Arthritis or Rheumatoid Conditions
☐	☐	☐	Asthma
☐	☐	☐	Birth Defects or Hereditary Problems
☐	☐	☐	Bleeding Disorders or Taking Blood Thinners
☐	☐	☐	Bone Fractures or Any Major Accidents
☐	☐	☐	Cancer or Tumor/Chemo/Radiation Treatments
☐	☐	☐	Cankers or Cold Sores (Mouth or Body)
☐	☐	☐	Diabetes (Adult or Juvenile Onset)
☐	☐	☐	Epilepsy, Seizures or Convulsions
☐	☐	☐	Eye, Ear, Nose, Throat, Tonsil or Adenoid Condition
☐	☐	☐	Fainting or Dizzy Spells

Yes	No	dk/u	
☐	☐	☐	Frequent Headaches, Colds or Sore Throat
☐	☐	☐	Handicapped or Disabled
☐	☐	☐	Heart Problem (Heart Defect, Murmur)
☐	☐	☐	Hepatitis (A, B or C) Jaundice or Other Liver Disorder
☐	☐	☐	Herpes
☐	☐	☐	High or Low Blood Pressure
☐	☐	☐	Immune System Conditions
☐	☐	☐	Kidney Disease
☐	☐	☐	Mental Health, Behavioral Problems or Depression
☐	☐	☐	Sickle Cell Anemia
☐	☐	☐	Tonsil or Adenoid Conditions
☐	☐	☐	Tuberculosis (TB)
☐	☐	☐	Ulcers (Stomach, Intestine, Mouth)
☐	☐	☐	Vision, Hearing, Tasting or Speech Difficulties

Are There Any Other Medical Conditions That We Should Be Aware Of?

Allergies or Reactions to any of the following:

Yes	No	dk/u	
☐	☐	☐	Local Anesthetics (Novocaine or Lidocaine)
☐	☐	☐	Aspirin
☐	☐	☐	Ibuprofen (Motrin, Advil)
☐	☐	☐	Penicillin or Other Antibiotics
☐	☐	☐	Sulfa Drugs
☐	☐	☐	Codeine or Other Narcotics
☐	☐	☐	Metals (Jewelry, Clothing Snaps)
☐	☐	☐	Acrylic
☐	☐	☐	Latex (Gloves, Balloons)
☐	☐	☐	Vinyl
☐	☐	☐	Is the Patient Taking Medications, Nutritional Supplements, Herbal Medications or Non-Prescription Medicines? Please List Below:

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Yes	No	dk/u	
☐	☐	☐	Does the Patient Have or Ever Had a Substance Abuse Problem?
☐	☐	☐	Does the Patient Chew or Smoke Tobacco?
☐	☐	☐	Operations? Describe:
☐	☐	☐	Hospitalized? For:
☐	☐	☐	Other Physical Problems or Symptoms? Describe:
☐	☐	☐	Being Treated by Another Health Care Professional? For:
☐	☐	☐	Date of Most Recent Physical Exam:

Females Only:

Yes	No	dk/u	
☐	☐	☐	Has the Patient Started Menstruation?
			If so, Approximately When? _____
☐	☐	☐	Is the Patient Taking Birth Control?
☐	☐	☐	Is the Patient Pregnant?
☐	☐	☐	Is the Patient Nursing?

Family Medical History

Do the Patient's Parents or Siblings Have Any of the Following Health Problems? If so, Please Explain:

Yes	No	dk/u		Yes	No	dk/u		Yes	No	dk/u	
☐	☐	☐	Bleeding Disorders	☐	☐	☐	Metabolic Disturbances	☐	☐	☐	Jaw Size Imbalance
☐	☐	☐	Diabetes	☐	☐	☐	Severe Allergies	☐	☐	☐	Any Other Medical Conditions That We Should Know About?
☐	☐	☐	Arthritis	☐	☐	☐	Unusual Dental Problems				

What other disease, condition, or problem does your child have that is not previously listed? _____

I certify that the above information is correct to the best of my knowledge. I understand I must notify Dr. Liz Gesenhues and/or her staff immediately at any time my information changes.

X _____
Signature Date

I authorize the release of medical/dental information to any of the following if needed: My child's physician, any other physician or dental offices he/she is referred to, attorneys (with my prior release by signature), and my insurance company.

X _____
Signature Date

I understand Dr. Liz Gesenhues may photograph my child's face and mouth for the purpose of documentation in his/her record. X_____ (Initial)
I further understand and grant my permission to Dr. Liz Gesenhues to use my child's photographs for educating other patients, prospective patients or other health care professionals, which may include but not be limited to, inclusion on Dr. Liz Gesenhues' website, office photographs or video.

X _____
Signature Date