McSweeney McSweeney McSweeney Orthodontics

CHILD / ADOLESCENT HEALTH HISTORY

We would like to welcome you and your child to our office!

Patient Name: _____ Nickname:_____ Sex: M F
Date of Birth: __ /____/_____ Age ____ Home Phone ( ) _____
Patient's Address: _____
Street City State Zip
Grade:_____ School: _____ City:_____
Patient's Dentist: _____ Date of Last Exam: __/__/___
Patient's Physician: _____ Date of Last Exam: __/__/___
Name (s) of other children seen in our office: _____

Who is accompanying the child today?

Name:_____ Relationship to Child: _____
Do you have legal custody of this child? Y N
Who may we thank for referring you to our office? _____

Responsible party / Parent information

Circle Parents' Marital Status: Married Widowed Separated Divorced Single

(Please check box next to parent responsible for account)

☐ **Father's Name**: _____Age: _____
Home Phone #:_____ Work Phone #:_____
Cell#:_____ ☐ √ if you want TEXT appointment reminders Email for appointment reminders: _____
Address: ☐ Same as Patient or
_____
Street City State Zip #Yrs at this Address
Employer: _____Date of Birth: _____
Social Security # _____ Dental Insurance Co:_____
Insurance ID # _____Group #:_____Ortho Coverage Y N

☐ **Mother's Name**: _____ Age: _____
Home Phone #:_____ Work Phone #:_____
Cell#:_____ ☐ √ if you want TEXT appointment reminders Email for appointment reminders: _____
Address: ☐ Same as Patient or
_____
Street City State Zip # Yrs at this Address
Employer: _____ Date of Birth: _____
Social Security # _____ Dental Insurance Co:_____
Insurance ID # _____ Group #:_____Ortho Coverage Y N

Patient's Dental History

What are the main concerns you would like orthodontics (braces) to accomplish? _____
_____

Y N Has an orthodontist been consulted previously? If yes, please list name of orthodontist _____ and date of consultation: _____

Y N Have there been any injuries to the face, mouth or teeth? _____

Y N Has your child been informed of any missing or extra permanent teeth? _____

Y N Is your child aware of any sores, lumps or irritated areas in the mouth? _____

Y N Does your child play a musical instrument? Please list: _____

Y N Does your child have any speech problems? _____

Y N Is your child concerned about the appearance of his/ her teeth? _____

Y N Is there anything that your child would like to change about his/ her smile? _____

Y N Does your child brush daily?

Y N Does your child floss daily?

Y N Thumb / Finger habit? Y N Lip sucking/ biting? Y N Nail biting?

Y N Any popping, clicking or jaw pain? Y N Clenching / Grinding Teeth?

Patient's Medical History

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 to which your child is **allergic:** _____
_____

Y N Is your child currently under the care of a physician? _____

Y N Has your child had tonsils and/ or adenoids removed? Age: _____

Y N Does your child have any history of major illness? _____

Y N Has your child ever been advised by a physician to take an antibiotic prior to any dental treatments?

Y N Has your child shown signs of increased growth recently?

Y N Reached puberty? (Girls) - Started menstruating? Y N (Boys) - Voice changed? Y N

Please circle Y or N regarding your child's treatments for any of the following:

Y N Tuberculosis
Y N Endocarditis
Y N Heart Condition
Y N Heart Pacemaker
Y N Heart Angina
Y N Heart Attack (Coronary)
Y N Mitral Valve Prolapse
Y N Congenital Heart Disease
Y N Artificial Heart Valve
Y N Heart Surgery (date_____)
Y N Heart Murmur
Y N Rheumatic Fever
Y N Prosthetic (artificial) joint
Y N X-Ray/Radiation (Cancer) Therapy
Y N AIDS or HIV Positive
Y N Diabetes

Y N Respiratory Lung Disease
Y N High Blood Pressure
Y N Hepatitis (type:____)
Y N Venereal Disease
Y N Herpes (oral cold sores)
Y N Blood Disorders/Bleeding Problems
Y N Inflammatory Rheumatism
Y N Arthritis
Y N Ulcers
Y N Stroke
Y N Anemia
Y N Asthma
Y N Epilepsy
Y N Glaucoma
Y N Fainting Spells

Y N ADD
Y N Kidney Trouble
Y N Liver Disease
Y N Psychiatric Treatment
Y N Drug Addiction
Y N Headaches
Y N Jaw Clicking
Y N Allergies
Y N Allergies to Metal
Y N Allergies to Latex
Y N Jaw Pain
Y N Tonsillitis
Y N Emotional Problems
Y N Other: _____
_____

I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct. THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE INFORMATION NOT DISCLOSED. I grant authority to the Doctor and Staff to perform all procedures and treatments in the patient's best interest. I understand that where appropriate, Credit Bureau reports may be obtained. I authorize the Orthodontist to share pertinent treatment information with collaborating dentists and specialists. Records sent to non- collaborating offices will be charged at $100 each. I authorize the billing of insurance for treatment procedures when appropriate.

Signature of Parent or Guardian: _____Date: _____

Signature of Orthodontist: _____Date: _____

Annual Update: Date: _____ Initials: _____
Date: _____ Initials: _____
Date: _____ Initials: _____
Date: _____ Initials: _____