# Child Health History Form

RANKIN & FIUME orthodontics
Creating smiles for a lifetime
608 McCarthy Blvd. • New Bern, NC 28562

## 1. Tell Us About Your Child

Today's Date: ____/____/_____

**Childs Name:** _____
LAST FIRST MI

Nickname:_____SS#_____

School:_____Grade____

**Child's Home Address:** _____

_____

Birth date: ____/____/_____ Age:_____ ☐ Male ☐ Female

Child's Home#:_____

Email Address_____

How do you prefer to be contacted?
☐ Phone ☐ Email ☐ Text ☐ Mail

## 2. Who Is Accompanying Your Child Today?

Name:_____Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

**Who may we thank for referring you?**

List brothers/sisters with age:

Parents Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Widowed

## 3. Mother's Information: ☐ Mother ☐ Step Mother

**Name:**_____**Birthdate**____/___/ _____

Work/Cell#:_____Home# _____

Employer:_____

Job Title:_____

**SS#:** _____

## 4. Father's Information: ☐ Father ☐ Step Father

**Name:**_____**Birthdate**___/___/_____

Work/Cell#:_____Home#: _____

Employer: _____

Job Title: _____

**SS#:** _____

## 5. Person Responsible for Financial/Account

**Name:**_____Relation:_____

Address:_____

_____

Primary#:_____**SS#:**_____

Employer:_____

Job Title/Occupation:_____

**Who is responsible for making appointments:**_____

## 6. Dentist Information

Dentist Name: _____

Last Dental Exam: _____ (month/year)

## 7. Orthodontic Insurance

**Primary**

Insurance Co. Name:_____

ID#: _____

**Insured Name:** _____

Relation: _____

**Insured's Birth date:**_____/_____/ _____

**Insured's Employer:** _____

**Secondary**

Insurance Co. Name:_____

ID#: _____

**Insured Name:** _____

Relation: _____

**Insured's Birth date:**_____/_____/ _____

**Insured's Employer:** _____

## 8. Medical History

Does the child have a personal Physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: _____ Date of last visit: _____

Is he/she taking any prescription medication?

☐ Yes ☐ No

If so, which ones? _____

_____

**For Girls:**

Are you pregnant? ☐ Yes ☐ No

Has menstruation begun? ☐ Yes ☐ No

| | Yes | No |
|---|---|---|
| Abnormal bleeding | ☐ | ☐ |
| Epilepsy | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Lung Disorder | ☐ | ☐ |
| Anemia | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ |
| HIV/Aids | ☐ | ☐ |
| Bone disorders | ☐ | ☐ |
| Kidney problems | ☐ | ☐ |
| Nervous disorders | ☐ | ☐ |
| Serious injury | ☐ | ☐ |
| Tumor or Cancer | ☐ | ☐ |
| Ear/Throat issues | ☐ | ☐ |
| Nasal/Sinus Problems | ☐ | ☐ |
| Heart Problems | ☐ | ☐ |
| Congenital Heart Defect | ☐ | ☐ |
| Hepatitis/Liver | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ |
| Heart Murmur | ☐ | ☐ |
| Radiation/Chemo | ☐ | ☐ |
| Asthma/Hay Fever | ☐ | ☐ |
| Gastrointestinal | ☐ | ☐ |
| Dizziness | ☐ | ☐ |
| Endocrine Disorder | ☐ | ☐ |
| Arthritis | ☐ | ☐ |
| Neural Disorder | ☐ | ☐ |

Type: _____

Are there any medical conditions we have not discussed that you feel we should be aware of?

**Does he/she normally require antibiotic pre-medication prior to dental procedures?** ☐ Yes ☐ No

**Is he/she allergic to any of the following?**

| | Yes | No |
|---|---|---|
| Aspirin | ☐ | ☐ |
| Codeine | ☐ | ☐ |
| Latex | ☐ | ☐ |
| Erythromycin | ☐ | ☐ |
| Nickel | ☐ | ☐ |
| Penicillin | ☐ | ☐ |

List Other Allergies:

## 9. Dental History

**Chief complaint/reason for visit today:**

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

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

Has your child ever had an injury to their mouth? ☐ Yes ☐ No

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

Has your child ever had a thumb/finger habit? ☐ Yes ☐ No ☐ Present ☐ Previous

Has your child's adenoids/tonsils been removed? ☐ Yes ☐ No

## 10. Consent

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.
I have received notice of privacy practices. I hereby consent to the making of any necessary diagnostic records, including xrays, to aid in the diagnosis and treatment plan for my child.

**Signature of parent or guardian** **Date**

Click to Submit