NORTH POTOMAC **ORTHODONTICS**

CHILD MEDICAL DENTAL HISTORY FORM

All information provided is confidential, protected by law, and used solely for medical care purposes. We will not disclose your data without your consent, except as legally required.

PATIENT

Today's date______________________

Last name____________________________________

First name_______________________ M.I.____

Preferred name________________________________

Birth date____________________________________

Assigned Sex: ☐Male ☐Female

Gender Identification: ☐Male ☐Female ☐Other:_______

Preferred pronouns_________________

Home address_________________________________

City, State, Zip code ____________________________

Primary phone #_______________________________

Email address(es)______________________________

School_______________________________________

Grade_________

Hobbies/Extracurriculars________________________

Siblings (name and age)____

PARENT/GUARDIAN

Parents' marital status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Parent/Guardian 1

Full name____________________________________

Relationship to patient__________________________

Birth date____________________________________

Social security #_______________________________

Address (if different)___________________________

____

Cell phone #__________________________________

Email_______________________________________

Occupation___________________________________

Parent/Guardian 2

Full name____________________________________

Relationship to patient__________________________

Birth date____________________________________

Social security #_______________________________

Address (if different)___________________________

____

Cell phone #__________________________________

Email_______________________________________

Occupation___________________________________

Who is financially responsible for this account (main billing party)? _____________________________________

Who will be responsible for bringing the patient to appointments? _____________________________________

EMERGENCY CONTACT

Person(s) OK to release appointment or medically related information to concerning child.

Name _______________________________ Phone # __________________________ Relation(s)______________

Name _______________________________ Phone # __________________________ Relation(s)______________

DENTAL INSURANCE

Primary Policy

Insurance company______________________________

Subscriber name______________________________

Subscriber birth date______________________________

Subscriber SSN______________________________

Member ID #______________________________

Group #______________________________

Employer______________________________

Secondary Policy

Insurance company______________________________

Subscriber name______________________________

Subscriber birth date______________________________

Subscriber SSN______________________________

Member ID #______________________________

Group #______________________________

Employer______________________________

DENTAL HISTORY

General Dentist______________________________ Last visit______________________________

How often does your child brush?____________________ How often does your child floss?____________________

How did you hear about our practice? ☐Doctor ☐Family or Friend ☐Ad ☐Internet ☐Other

Name of person referring (if applicable) ____

Main concerns about their teeth?____

Has your child visited an orthodontist before? ☐Y ☐N

If yes, when?______________________________ Reason?______________________________

Have we treated any other family members? ☐Y ☐N

If yes, please name____

Now or in the past, has your child had:

☐Y ☐N Tonsils or adenoids removed?

☐Y ☐N Jaw pain or discomfort (TMJ/TMD)?

☐Y ☐N Missing or extra permanent teeth?

☐Y ☐N Injury to the mouth, teeth, or chin?

☐Y ☐N History of speech problems?

☐Y ☐N Chewing/eating problem?

☐Y ☐N Frequent habit of nail biting?

☐Y ☐N Frequent habit of thumb/finger sucking?

☐Y ☐N Frequent habit of lip sucking/biting?

☐Y ☐N Mouth breathing habit or snoring?

☐Y ☐N Teeth grinding or clenching?

MEDICAL HISTORY

Patient's Physician______________________________ Phone #______________________________

Last visit______________________________ Reason______________________________

Does your child have any diagnosed or suspected emotional, sensory, or developmental conditions? **☐Y ☐N**

If yes, please describe____

Does your child have any allergies/sensitivities to medications, metal, or latex? **☐Y ☐N**

If yes, please list____

Is your child currently taking any prescription or over-the-counter medication? **☐Y ☐N**

If yes, please list (with dosage)____

Has your child had any serious illnesses or operations? ☐**Y** ☐**N**

If yes, please describe____

Has your child ever had a blood transfusion? ☐**Y** ☐**N**

If yes, give approximate dates____

Has your child ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate), or Didronel (etidronate)? ☐**Y** ☐**N**

Has your child ever taken oral medication for bone disorders or cancers such as bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate), or Didronel (etidronate)? ☐**Y** ☐**N**

IF APPLICABLE *(select all that apply)*:

☐Menstruation has begun	☐Currently pregnant	☐Currently nursing	☐Currently taking birth control pills

Now or in the past, has your child had *(select all that apply)***:**

☐ADHD	☐Chemotherapy	☐Heart Problems	☐Respiratory Disease
☐Anemia	☐Circulatory Problems	☐Hemophilia	☐Rheumatic Fever
☐Anxiety	☐Cortisone Treatments	☐Hepatitis	☐Scarlet Fever
☐Arthritis, Rheumatism	☐Cough, Persistent	☐High Blood Pressure	☐Shortness of Breath
☐Artificial Heart Valves	☐Coughing Blood	☐High Cholesterol	☐Skin Rash
☐Artificial Joints	☐Diabetes	☐HIV/AIDS	☐Stroke
☐Asthma	☐Depression	☐Jaw Pain	☐Swelling of Feet/Ankle
☐Autism Syndrome Disorder	☐Eating Disorder	☐Kidney Disease	☐Thyroid Problems
☐Autoimmune Disease	☐Epilepsy	☐Liver Disease	☐Tobacco Habit
☐Back Problems	☐Fainting	☐Mital Valve Prolapse	☐Tonsillitis
☐Blood Disease	☐Glaucoma	☐Osteoporosis	☐Tuberculosis
☐Cancer	☐Headaches	☐Pacemaker	☐Ulcer
☐Chemical Dependency	☐Heart Murmur	☐Radiation Treatment	☐Venereal Disease (STD)

AUTHORIZATION

I have read the above questions and understand them. The above questions have been accurately answered. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I understand that it is my responsibility to notify my orthodontist of any changes in my child's medical or dental health.

I authorize the release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance.

Parent/Guardian Signature_______________________________ Date_____________________