prestwich ORTHODONTICS

PATIENT HEALTH HISTORY CHILD

PATIENTS NAME: _____ Sex: _____ Age: _____ Birthday: _____

Nickname: _____ Mailing Address: _____

City: _____ State: _____ Zip: _____ Patient Phone: _____ School: _____ Grade: _____

Preferred way to be contacted: ☐ Call ☐ Email ☐ Mail ☐ Text ☐ Other:_____

Person Responsible for Account: ☐ Father ☐ Mother ☐ Guardian ☐ Other _____

Father's Name: _____ Cell Phone: _____ Father's Employer: _____

Mother's Name: _____ Cell Phone: _____ Mother's Employer: _____

Father's Email: _____ Mother's Email: _____

Parents Marital Status: ☐ Married ☐ Single ☐ Divorced---Patient Resides With: ☐Father ___% ☐Mother ___% ☐Both ___% ☐Guardian __%

Guardian (If applicable): _____Cell Phone: _____Email: _____

Step-Dad's Name: _____Cell phone: _____Email: _____

Step-Mom's Name: _____Cell phone: _____Email: _____

Siblings' Names and DOB: _____

DENTAL INSURANCE

Primary Insurance Company: _____Contract #: _____

Insured's (parent/step-parent) Name: _____ Birthdate: _____ SS# _____

Insured's Address if different from above: _____

Employer: _____ Work Phone: _____ Ortho Coverage? ☐ Yes ☐ No

Secondary Insurance Company: _____Contract #: _____

Insured's (parent/step-parent) Name: _____ Birthdate: _____ SS# _____

Insured's Address if different from above: _____

Employer: _____ Work Phone: _____ Ortho Coverage? ☐Yes ☐No

DENTAL HISTORY

Patient's Dentist: _____ Date of Last Visit: _____

Referred by: ☐ Dentist ☐ Facebook ☐ Google ☐ Billboard Ad ☐ Radio Ads ☐ Friend/Patient: Name_____ ☐ Other:

Reason for consultation (Chief Concern): _____ Preferred method of treatment: ☐ Braces ☐ Clear Aligners ☐ Doctors Choice

What aspect of orthodontic treatment is the patient most concerned about? ☐ Quality ☐ Cost ☐ Discomfort ☐ Time

☐ Yes ☐ No Has an orthodontist been consulted previously? Name: _____ Date: _____

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

☐ Yes ☐ No Has the patient had or presently have any of the following habits? Check all that apply.

☐ Thumb or Finger Sucking ☐ Lip Biting ☐ Snoring ☐ Grinding Teeth at Night ☐ Mouth Breathing

☐ Yes ☐ No Has the patient been informed of any missing or extra teeth?

☐ Yes ☐ No Is the patient aware of any sores, lumps or irritated areas in the mouth?

☐ Yes ☐ No Has the patient been treated for: ☐ Bad Bite ☐ TMJ ☐ Periodontal Disease

☐ Yes ☐ No Is the patient frightened or anxious about orthodontic treatment?

☐ Yes ☐ No Is the patient concerned about the appearance of their teeth? Explain: _____

MEDICAL HISTORY

☐ Yes ☐ No Is the patient's general health good at this time? Primary Physician: _____Last Exam: _____

☐ Yes ☐ No Is the patient taking any medication? Name: _____

☐ Yes ☐ No Is the patient allergic to any medication? (Penicillin, Sulfa, etc.) Name: _____

☐ Yes ☐ No Has the patient had tonsils and/adenoids removed? Age: _____

☐ Yes ☐ No Has the patient ever had a serious illness or been hospitalized? Explain: _____

☐ Yes ☐ No Does the patient have any special problems not listed? Explain: _____

☐ Yes ☐ No Has the patient ever been advised by their physician to take an antibiotic prior to any dental treatments?

If yes, antibiotic name and method: _____

☐ Yes ☐ No Does the patient use tobacco products?

Does the patient now, or have they ever had any of the following?

☐ AIDS or H.I.V. Positive	☐ Diabetes	☐ Hepatitis; Type _____	☐ Pregnant
☐ Allergies	☐ Drug Addiction	☐ Herpes (Oral-Cold Sores)	☐ Prosthetics
☐ Allergies to Latex	☐ Earaches	☐ High Blood Pressure	☐ Radiation Therapy
☐ Allergies to Metal	☐ Eating Disorder	☐ Inflammatory Rheumatism	☐ Respiratory Lung Disease
☐ Anemia	☐ Emotional/Mental Health Issues	☐ Insomnia	☐ Rheumatic Fever
☐ Artificial Heart Valve	☐ Epilepsy	☐ Jaw Clicking/Jaw Pain	☐ Stroke
☐ Arthritis	☐ Fainting Spells	☐ Kidney Trouble	☐ Tonsillitis
☐ Asthma	☐ Glaucoma	☐ Liver Disease	☐ Tuberculosis
☐ Autism Spectrum Disorder	☐ Headaches	☐ Low Blood Pressure	☐ Ulcers
☐ Blood Disorder	☐ Heart Attack (Coronary)	☐ Mitral Valve Prolapse	☐ Other: _____
☐ Chronic Sinusitis	☐ Heart Condition: _____	☐ Osteoporosis-Bisphosphonates	

I, 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 treatment in the patient's best interest. I understand that, when appropriate, Credit Bureau reports may be obtained. I authorize the orthodontist to share pertinent treatment information with collaborating dentists and surgeons when appropriate. I authorize the orthodontist to submit treatment information pertinent to this patient to the insurance company for billing purposes only.

Signature of Parent/Guardian: _____

I acknowledge receipt of Prestwich Orthodontics Notice of Privacy Practices *(You may refuse to sign this acknowledgement)*:

Signature of Parent/Guardian: _____Today's Date:_____

For office use only:

Signature of Office Witness: _____Today's Date: _____

Bracket Choice: ☐Stainless_____ ☐Clear Aligners _____ ☐Clear Braces