Please respond to all questions

Child/Adolescent Health History

Geyer Orthodontics, P.C.

Specialists in Orthodontics

NAME_____ Prefers to be called "_____" Male ❑ Female ❑

Child lives with: Both Parents ❑ Mother ❑ Father ❑ Other ❑ _____

Favorite School Subjects_____ What is the general quality of the child's school work?_____

Hobbies-Sports-Musical Instruments_____

Has anyone in the family had braces?_____Who?_____ Were you/they pleased with the results?_____

Whom may we thank for referring you to our office?_____ General Dentist_____

How often does your child see the dentist?_____ Date of last dental exam (Mo./Yr.)_____

What are the main concerns that you would like orthodontics to address?_____

Has your child been evaluated for or had orthodontic treatment before?	Y	N
Is your child self-conscious of his/her teeth?	Y	N
Have there been any injuries to the face, mouth, teeth or chin?	Y	N
Have adenoids and/or tonsils been removed?	Y	N
Have you been informed that he/she is missing or has extra permanent teeth?	Y	N
Has your child ever had any pain/tenderness in his/her jaw joint (TMJ)?	Y	N
Does your child have any dental problems at this time (pain, cavities, etc.)?	Y	N
Does your child have a fear of dentists?	Y	N

Does your child have any of the following habits?

Thumb/finger sucking Past/Present	Y	N	Speech problems	Y	N
Mouth breathing	Y	N	Finger nail biting	Y	N
Clenching/grinding	Y	N	Tongue thrust	Y	N

Is your child allergic to any of the following?

Penicillin	Y	N	Nickel	Y	N
Latex	Y	N	Any other medication	Y	N

Other allergies:_____

If any of your answers are 'Y', what happens when your child is exposed to the allergen?_____

MEDICAL INFORMATION

Did/does your child have:

Any health problem	Y	N
Any hospitilizations	Y	N
To take any medications	Y	N
Please list them_____		
Abnormal delivery as infant	Y	N
Rheumatic fever, heart disease heart murmur	Y	N
Latex Sensitivity	Y	N
Asthma/respiratory problems	Y	N
Prolonged bleeding or anemia	Y	N
Thyroid or hormone therapy	Y	N
Recurrent or chronic illness	Y	N

Child's Physician:_____

Ulcers	Y	N
Severe headaches	Y	N
Pain of head/face	Y	N
Diabetes	Y	N
Psychiatric counseling	Y	N
Blood transfusions	Y	N
Hepatitis	Y	N
Tuberculosis	Y	N
AIDS/HIV virus	Y	N
Mouth/lip lesions (sores)	Y	N
Periodontal Disease	Y	N
Epilepsy/seizures	Y	N
Other infections	Y	N

Please explain any "Y" answers above_____

Child's height:_____ Child's weight:_____ Biological Father's height:_____ Biological Mothers height :_____

Has your child:

if male - had voice changes? Y N

- had facial hair growth? Y N

if female - begun menstruation Y N

- approx. date (Mo./Yr.)_____/_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information 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.

_____ Signature

_____ Date

(OVER)

For Office Use Only

TMD HX - WNL CL/POP O-LOCK C-LOCK R L OTHER_____ REC TFR POL EXP_____

Updates (date & initial)_____ _____ _____ _____

A B C

Patient Information

Date_____

Patient's Name_____
Last First Middle

Address_____
Street City State Zip

Home Phone_____ Birthdate_____ Social Security #_____

School_____ Grade_____

Responsible Party Information

Name_____ _____ _____
Last First Middle Marital Status E-Mail Address

Residence_____
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address? _____ Cell Phone (Mom) _____

Home Phone_____ Work Phone_____ Cell Phone (Dad) _____

Previous Address (if less than 3 years)_____
Street City State Zip

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. Years Employed_____

Spouses Name_____ Relationship to Patient_____

Employer_____ Occupation_____ No. Years Employed_____

Social Security #_____ Birthdate_____ Work Phone_____

Orthodontic Insurance Information

Policy Holder's Name_____ Soc. Sec. or Alternate ID#_____

Insurance Company_____ Group No._____ Policy Holder's B-day_____

Insurance Co. Address_____

Policy Holder's Employer_____

Do you have dual coverage? Yes ☐ No ☐ **If yes:** Insurance Phone #_____

Policy Holder's Name_____ Soc. Sec. or Alternate ID#_____

Insurance Company_____ Group No._____ Policy Holder's B-day_____

Insurance Co. Address_____

Policy Holder's Employer_____ Insurance Phone #_____

Emergency Information

Name of nearest relative not living with you_____

Complete address_____

Home Phone_____ Work Phone_____ Cell Phone _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parents signature if minor)_____

Updates (date & initial)_____ _____ _____ _____

CONFIDENTIAL (for record and pretreatment evaluation)