PREMIER Orthodontics

PATIENT HISTORY - CHILD

Child's Name____ Male / Female
Last Name First Name Initial Nickname

Address ____

City ____________________ State ________ Zip __________ Email ____________________

Home Ph# ____________________ Cell Ph# ____________________ Cell Carrier____________________

Birthdate ______/______/______ Age __________ School Attending ____________________

Hobbies/Interests ____

WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name____________________________ Relation to Patient____________________

Whom may we thank for referring you? ____________________________

PRIMARY RESPONSIBLE PARTY

Person Responsible for Account ____________________________ Male / Female
Last Name First Name Initial Marital Status

Relation to Patient ______________ Birthdate______/______/______ Soc. Sec. #____________________

Address (**if different from above**)____________________________

Cell #____________________ Cell Carrier ______________ Email____________________

Employer____________________________ Occupation ____________________

Business Address ____________________________ Business Ph# ____________________

Insurance Company____________________________ Phone #____________________

Subscriber ID#____________________________ Group/Policy # ____________________

SECONDARY RESPONSIBLE PARTY

Person Responsible for Account ____________________________ Male / Female
Last Name First Name Initial Marital Status

Relation to Patient ______________ Birthdate______/______/______ Soc. Sec. #____________________

Address (**if different from above**)____________________________

Cell #____________________ Cell Carrier ______________ Email____________________

Employer____________________________ Occupation ____________________

Business Address ____________________________ Business Ph# ____________________

Insurance Company____________________________ Phone #____________________

Subscriber ID#____________________________ Group/Policy # ____________________

Please complete both sides

DENTAL HISTORY

Dentist ____ Date of Last Dental Exam ____________________

Circle (Yes / No) if your child has had problems with any of the following:

Bad Breath	Yes / No	Bleeding gums	Yes / No	Clicking, popping, locking of jaw	Yes / No
Sensitivity to cold	Yes / No	Sensitivity to hot	Yes / No	Food collecting between teeth	Yes / No
Sensitivity to sweets	Yes / No	Periodontal treatment	Yes / No	Grinding/clenching teeth	Yes / No
Sores in mouth	Yes / No	Loose/Broken teeth	Yes / No	Thumb/finger sucking	Yes / No
Mouth breathing	Yes / No	Snoring	Yes / No	Nail biting	Yes / No

Any injuries to mouth or chin injury Yes / No If yes please explain ____

Has your child ever been evaluated for orthodontic treatment? Yes / No Orthodontist_____________________________

MEDICAL HISTORY

Physician's Name ____ Phone # ___________________________________

Any recent illness(or)surgeries Yes / No If yes describe____

Is your child currently under physician care Yes / No If yes, describe ___________________________________

Do your child still have: Tonsils Yes / No Adenoids Yes / No

For Women: Are you pregnant? Yes / No Taking birth control pills Yes / No

Circle (Y: Yes or N: No) whether your child has (or) had any of the following:

AIDS/HIV+	Y / N	Hepatitis	Y / N	High Blood pressure	Y / N	Stroke	Y / N
Anaphylaxis	Y / N	Diabetes	Y / N	Epilepsy	Y / N	Asthma	Y / N
Fainting	Y / N	Hemophillia	Y / N	Cancer	Y / N	Heart attack	Y / N
Sinus Prob.	Y / N	Heart Murmur	Y / N	Congenital Heart Def.	Y / N	Jaw Pain	Y / N
Headaches	Y / N	Kidney Disease	Y / N	Liver Disease	Y/ N	Tuberculosis	Y / N
Cold Sores	Y / N	Drug/Alcohol abuse	Y / N	Mitral Valve Prolapse	Y / N	Rheum Fever	Y / N

Is your child taking any medication for your bones? Yes / No If yes, List______________________________________
Is your child currently taking any medications? Yes / No If Yes, List____
Does your child have any drug allergies? If Yes, List all: ____

Allergic to LATEX YES / NO

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the orthodontic staff to perform the necessary orthodontic services my child may need.

I authorize OrthoBanc LLC, on behalf of Dr. Dustin Coles, to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options.

I have also read, understand and have been offered a copy of the HIPPA consent form.

____ ____________________________

Signature **Date**