Skopek Orthodontics
Medical/Dental History - Child

Date:________________________ Referred by: ______________________

Patient's Name: Sex: M / F Age: Birthdate: / /

Prefers to be addressed as: School: Grade: E-mail Address:

Address City: State: Zip: Phone:

Father's Name: Occupation: Work Phone:

Father's Employer: SS#: Cell #:

Mother's Name: Occupation: Work Phone:

Mother's Employer: SS#: Cell #:

Parent's Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Guardian: Phone #: Cell #:

Guardian's Employer: Occupation: Work Phone:

Person Responsible for Account: ❑ Father ❑ Mother ❑ Guardian ❑ Other (State Name):

Address: SS#: Phone:

Other Children in Family: Name: DOB:

Name: DOB: Name: DOB:

DENTAL INSURANCE

Primary Insurance Co: Gr. #: Ortho Coverage ❑ Yes ❑ No

Insured's Name: SS#: Birthdate:

Secondary Insurance Co: Gr. #: Ortho Coverage ❑ Yes ❑ No

Insured's Name: SS#: Birthdate:

Other Insurance Information:

DENTAL HISTORY

1. Patient's Dentist: Date of Last Visit:
2. Have there been any injuries to the face, mouth or teeth? ❑ YES ❑ NO
3. Has the patient had or presently have any of the following habits? ❑ NO ❑ Thumb or finger sucking ❑ Lip Biting ❑Snoring ❑Grinding of teeth at night ❑Mouth Breathing
4. Has the patient been informed of any missing or extra permanent teeth? ❑ YES ❑ NO
5. Is the patient aware of sores, lumps or irritated areas of the mouth? ❑ YES ❑ NO
6. Has an orthodontist been consulted previously? ❑ YES ❑ NO
   Name: Date:
7. Has the patient ever been treated for: ❑ Bad Bite ❑ TMJ ❑Periodontal Disease
   If so, by whom?:
8. Does the patient have any speech problems? ❑ YES ❑ NO
9. Is the patient frightened or anxious about Orthodontic treatment? ❑ YES ❑ NO
10. Is the patient concerned about the appearance of his/her teeth? ❑ YES ❑ NO
11. Is there anything the patient would like to change about his/her smile? ❑ YES ❑ NO
    If so, what:
12. What aspect of dental treatment is the patient most concerned with? ❑ Quality ❑ Cost ❑ Discomfort ❑ Time
13. Reason for consultation (chief concern):
14. Has any other family member had orthodontic treatment? ❑ YES ❑ NO
    Are you satisfied with the results? ❑ YES ❑ NO
    Mother (Dr.____________) Father (Dr.____________) Brothers (Dr.____________) Sisters (Dr.____________)

MEDICAL HISTORY

1. Is the patient's general health good at this time?	❑ YES	❑ NO
2. What is the name of the family physician?	Date of last physical:	
3. Is the patient under the care of a physician at this time? Explain:	❑ YES	❑ NO
4. Is the patient taking any medication? (List meds under notes)	❑ YES	❑ NO
5. Is the patient allergic to any medication? (Penicillin, Sulfa, etc.) Name:	❑ YES	❑ NO
6. Has the patient had tonsils and/or adenoids removed? Age:	❑ YES	❑ NO
7. Has the patient ever had a serious illness or been hospitalized? Explain:	❑ YES	❑ NO
8. Does the patient have any special problems not listed? Explain:	❑ YES	❑ NO
9. Has the patient ever been advised by your physician to take an antibiotic prior to any dental treatments? If yes, antibiotic name and method:	❑ YES Reason?	❑ NO
10. Does the patient use tobacco? (smoking or chewing)	❑ YES	❑ NO
11. What is the patient's approximate height?	Weight?	
12. Has the patient shown signs of increased growth recently?	❑ YES	❑ NO
13. Has the patient reached puberty?	❑ YES	❑ NO
Girls - start menstruating?	❑ YES	❑ NO
Boys - voice changed?	❑ YES	❑ NO

14. Father's present height:____________________ Mother's present height:____________________

Older brother's present height:____________________ Older sister's present height:____________________

DOES THE PATIENT NOW, OR HAVE THEY EVER HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
❑	❑	TUBERCULOSIS	❑	❑	RESPIRATORY LUNG DISEASE	❑	❑	ADD/ADHD
❑	❑	ENDOCARDITIS	❑	❑	HIGH BLOOD PRESSURE	❑	❑	KIDNEY TROUBLE
❑	❑	HEART CONDITION	❑	❑	LOW BLOOD PRESSURE	❑	❑	LIVER DISEASE
❑	❑	HEART PACEMAKER	❑	❑	HEPATITIS (type?______)	❑	❑	PSYCHIATRIC TREATMENT
❑	❑	HEART ANGINA	❑	❑	VENEREAL DISEASE	❑	❑	DRUG ADDITION
❑	❑	HEART ATTACK	❑	❑	HERPES (ORAL-COLD SORES)	❑	❑	HEADACHES
❑	❑	MITRAL VALVE PROLAPSE	❑	❑	BLOOD DISORDERS/BLEEDING PROBLEMS	❑	❑	EARACHES
❑	❑	CONGENITAL HEART DISEASE	❑	❑	INFLAMMATORY RHEUMATISM	❑	❑	JAW CLICKING
❑	❑	ARTIFICIAL HEART VALVE	❑	❑	ARTHRITIS	❑	❑	ALLERGIES
❑	❑	HEART SURGERY;date _____	❑	❑	ULCERS	❑	❑	ALLERGIES TO METAL
❑	❑	HEART MURMUR	❑	❑	STROKE	❑	❑	JAW PAIN
❑	❑	RHEUMATIC FEVER	❑	❑	ANEMIA	❑	❑	TONSILLITIS
❑	❑	PROSTHETIC (ARTIFICIAL) JOINT	❑	❑	ASTHMA	❑	❑	EMOTIONAL PROBLEMS
❑	❑	X-RAY/RADIATION (CANCER) THERAPY	❑	❑	EPILEPSY	❑	❑	BLOOD TRANSFUSION
❑	❑	AIDS OR H.I.V. POSITIVE	❑	❑	GLAUCOMA	❑	❑	OTHER: ____________
❑	❑	DIABETES	❑	❑	FAINTING SPELLS	❑	❑	

MEMO:

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I, the 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. I grant authority to the Doctor and Staff to perform all procedures and treatments in my best interest. I authorize the Orthodontist to share 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. I understand that, when appropriate, Credit Bureau reports may be obtained.

Signature of parent or guardian

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Signature of Orthodontist

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Today's Date ____________________

Update ____________________ Initial______

Update ____________________ Initial______

Update ____________________ Initial______

Update ____________________ Initial______

NOTES:

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