BURNS PARK
ORTHODONTICS, P.C.

1303 PACKARD STREET, SUITE 101
ANN ARBOR, MICHIGAN 48104-3874
(734) 761-3116

CHILD'S PERSONAL HEALTH RECORD

Patient's Name ________________________________ Nickname _____________ Age ____ Sex ____
Address ____ Pronoun(s) _________
Preferred Phone _____________________ Birthdate ______________ School __________ Grade ____
No. of children in family __________ Age & Gender ____
Patient's Dentist ____ Physician _____________________
Who may we thank for referring you? ____
Parent/Guardian #1 ________________________________ E-mail _____________________________
Employer ____ Phone ______________________________
Parent/Guardian #2 ________________________________ E-mail _____________________________
Employer ____ Phone ______________________________
Parents' Marital Status: Married _____ Divorced _____ Single _____ Separated _____ Widowed _____

Person responsible for the account ____
Address ____ Preferred Phone ____________________
Employer ____ Work Phone ______________________

ORTHODONTIC INSURANCE

Primary Insurance Co. _______________________ Group# ________________ Birthdate _______
Subscriber Name ___________________________ ID#/SS# ________________________________
Secondary Insurance Co. _____________________ Group# ________________ Birthdate _______
Subscriber Name ____________________________ ID#/SS# _______________________________

MEDICAL HISTORY

1. Is the patient in good health? ____ Yes _____ No _____
2. Is the patient presently under a physician's care? ____________________________________ Yes _____ No _____
3. Has the patient ever been severely ill or hospitalized? __________________________________ Yes _____ No _____
4. List any drugs or medicines currently being taken (dosage and reason) ______________________________________
5. List any drug sensitivities or allergies of which you are aware ____
6. Females only: At what age did menses start? ___________ or N/A
7. Check any of the following conditions for which the patient has been treated

_____ Diabetes
_____ Pneumonia
_____ Asthma
_____ Tuberculosis
_____ Kidney Disease
_____ Hepatitis/Liver Disease
_____ STIs
_____ HIV/AIDS
_____ Congenital Abnormalities
_____ Anemia
_____ Prolonged Bleeding
_____ Fainting/Dizziness
_____ Heart Condition
_____ High/Low Blood Pressure
_____ Heart Murmur
_____ Rheumatic Fever
_____ Pacemaker/Heart Valve
_____ Osteoporosis/Bone Disorder
_____ ADHD
_____ Autism
_____ Anxiety Disorder
_____ Depression/OCD
_____ Eating Disorder
_____ Epilepsy
_____ Frequent Colds/Sore Throat
_____ Tonsils/Adenoids Removed
_____ Speech Therapy

DENTAL HISTORY

1. Have you had a recent dental exam or treatment? ____________________ Date ______________________ Yes _____ No _____
2. Have you had a previous orthodontic exam or treatment? ______________________________________ Yes _____ No _____
3. Have there ever been any injuries to the mouth, face, or teeth? _________________________________ Yes _____ No _____
4. Have you ever had teeth extracted? ____ Yes _____ No _____
5. Have you ever been informed of missing or extra teeth? _______________________________________ Yes _____ No _____
6. Have you had, or presently have, any of the following habits? __________________________________ Yes _____ No _____

   _____ Thumb or Finger Sucking _____ Lip Biting _____ Snoring

   _____ Grinding Teeth at Night _____ Mouth Breathing

7. Do you have frequent cold or canker sores? ____ Yes _____ No _____
8. Do you ever complain of swollen, tender, or bleeding gums? ___________________________________ Yes _____ No _____
9. Are you aware of a tired, tense feeling in the facial muscles or joints of the jaw? _____________________ Yes _____ No _____
10. Are you especially apprehensive toward dental visits? ____ Yes _____ No _____
11. a.) Do other family members have similar conditions? _______________________________________ Yes _____ No _____

    b.) Have any family members had orthodontic treatment? _____________________________________ Yes _____ No _____
12. Reason for this exam (chief concern) ____
13. List hobbies, sports, and musical instruments played ____

    ____
14. List any other pertinent health or dental history here ____

    ____

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize and request my insurance company to pay directly to the orthodontist the insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf. I give consent to Burns Park Orthodontics to use and disclose my protected health information to carry out treatment, payment activities, and healthcare operations.

X ____ ____________________

SIGNATURE DATE