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Orthodontics **Telephone 734/761-3116**

Child's Personal Health Record

Patient's Name _____ Nickname _____ Age _____ Gender _____
Address _____ City _____ Zip _____
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 _____ Cell Phone _____
Employer _____ Work Phone _____
Parent/Guardian #2 _____ Cell Phone _____
Employer _____ Work 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#_____ Phone _____
Subscriber Name _____ ID#/SS# _____ Birthdate _____
Secondary Insurance Co. _____ Group# _____ Phone _____
Subscriber Name _____ ID#/SS# _____ Birthdate _____

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 now being taken. (Give dosage and reason) _____
5. List any drug sensitivities or allergies of which you are aware. _____
7. Check any of the following conditions for which the patient has been treated:

_____ Diabetes
_____ Pneumonia
_____ Asthma
_____ Tuberculosis
_____ Kidney Disease
_____ Hepatitis/Liver Disease
_____ STD
_____ 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

Other _____

Dental History

1. Has the patient had a recent dental exam or treatment? _____ Date _____ Yes ____ No ____
2. Has the patient 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. Has the patient ever had teeth extracted? _____ Yes ____ No ____
5. Have you ever been informed of missing or extra teeth? _____ Yes ____ No ____
6. Has the patient 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. Does the patient have frequent cold or canker sores? _____ Yes ____ No ____
8. Does the patient ever complain of swollen, tender, or bleeding gums? _____ Yes ____ No ____
9. Is the patient aware of a tired, tense feeling in the facial muscles or joints of the jaw? _____ Yes ____ No ____
10. Is the patient especially apprehensive toward dental visits? _____ Yes ____ No ____
11. a.) Have other family members had 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. _____

_____

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 child's 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 Drs. Clinthorne and Kim's office to use and disclose my child's protected health information to carry out treatment, payment activities, and healthcare operations.

X _____ _____

SIGNATURE **DATE**