BURNS PARK ORTHODONTICS, P.C.

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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 ____________ 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 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. ____

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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