ADVANTAGE ORTHODONTICS
Smiles by Dr. Ford

CHILD PATIENT HEALTH HISTORY INFORMATION

Patient's Name*

Gender: Male ☐ Female ☐

Preferred Name

Date of Birth*

Home Street Address*

City & State*

Zipcode*

Patient Phone #

Other Family Members Seen By Us

School

Hobbies

Who Referred You To Our Office?

Names & ages of siblings?

General Dentist's Name

Family Physician's Name

Dentist's Phone Number

Physician's Phone Number

Date of Last Exam

Date of Last Exam

May we contact you using? (check all that apply) - Text ☐ Email ☐ Mobile ☐

PARENT/GUARDIAN INFORMATION

PATIENT'S MOTHER

Name*

Employer

Employer Name

Mobile Phone*

Home Phone

Social Security Number

Email*

PATIENT'S FATHER

Name*

Employer

Employer Name

Mobile Phone*

Home Phone

Social Security Number

Email*

Marital Status - Single ☐ Married ☐ Divorced ☐ Widowed ☐

Patient lives with - Mother ☐ Father ☐ Both ☐ Other ☐

Is patient adopted? - Yes ☐ No ☐

INSURANCE INFORMATION

Do you have dental insurance that includes an orthodontic benefit? Yes ☐ No ☐

If yes, please complete the following:

Primary Coverage

Policy Holder's Name*	Date of Birth*
Place of Employement*	Social Security Number*
Insurance Carrier*	Group Number*
Policy Number*	Carrier Phone # (if you'd like us to check on your benefit)

Secondary Coverage

Do you have secondary insurance that includes an orthodontic benefit? Yes ☐ No ☐

If yes, please complete the following:

Policy Holder's Name	Date of Birth
Place of Employement	Social Security Number
Insurance Carrier	Group Number
Policy Number	Carrier Phone # (if you'd like us to check on your benefit)

MEDICAL HISTORY

The following information is required to enable us to provide your child with the best possible care. All information is strictly private and is protected by doctor-patient confidentiality. The orthodontist will review your medical history and explain any questions that you do not understand.

Is your child being treated for any medical condition at this time or has s/he been treated for a medical condition within the past two years? Yes ☐ No ☐

If yes - please explain

Has there been a change in your child's health within the past two years? Yes ☐ No ☐

If yes - please explain

Is your child currently taking any medications, non-prescription drugs, or herbal supplements? Yes ☐ No ☐

If yes - please explain

Does your child have any allergies? If yes, please list using the categories below. Yes ☐ No ☐

Medications
Latex and/or rubber products
Other (e.g.; foods, hayfever, etc.)

Has your child had his/her adenoids and/or tonsils removed? Yes ☐ No ☐

Does your child have any conditions or therapies that could affect their immune system (e.g., leukemia, AIDS, HIV, radiotherapy, chemotherapy)? Yes ☐ No ☐

Has your child ever been hospitalized for any illnesses or operations? Yes ☐ No ☐

If yes - please explain

Has your child ever been treated by a physician for:

Yes	No	?		Yes	No	?	
☐	☐	☐	Cancer	☐	☐	☐	Cerebral Palsy
☐	☐	☐	Heart Murmur	☐	☐	☐	Seizures
☐	☐	☐	Heart disease	☐	☐	☐	Asthma
☐	☐	☐	Rheumatic Fever	☐	☐	☐	Cleft Lip/Palate
☐	☐	☐	Anemia	☐	☐	☐	Speech or Hearing Problems
☐	☐	☐	Sickle Cell Anemia	☐	☐	☐	Eye Problems/Contact Lenses
☐	☐	☐	Abnormal Bleeding/Hemophilia	☐	☐	☐	Skin Problems
☐	☐	☐	Blood Tranfusions	☐	☐	☐	Tonsils/Adenoids/Sinus Problems
☐	☐	☐	Hepatitis	☐	☐	☐	Endocrine Problems
☐	☐	☐	AIDS/HIV+	☐	☐	☐	Artificial Joints/Valves
☐	☐	☐	Tuberculosis	☐	☐	☐	Headache/Migranes
☐	☐	☐	Liver Disease	☐	☐	☐	Sleep Problems
☐	☐	☐	Kidney Disease	☐	☐	☐	Radiation Therapy
☐	☐	☐	Diabetes	☐	☐	☐	Osteoporosis (bisphosphonates)
☐	☐	☐	Arthritis				

Does your child have any other medical conditions? Yes ☐ No ☐

If yes - please explain

Is your child in good health? Yes ☐ No ☐

DENTAL HISTORY

What concerns do you have about your child's teeth/smile?

Please explain

Is your child nervous during dental treatment? Yes ☐ No ☐

Is your child a mouth-breather while sleeping or awake (or both?) Yes ☐ No ☐

Has your child ever had a habit such as thumb or finger sucking, nail biting, lip sucking, grinding teeth, or an unusual swallow pattern? Yes ☐ No ☐

Have you ever been informed that your child has any missing or extra permanent teeth? Yes ☐ No ☐

Have there been any injuries to your child's face, mouth, or teeth? Yes ☐ No ☐

Has your child experienced any jaw joint noises, pain, or limited movement? Yes ☐ No ☐

Have you previously consulted an orthodontist? Yes ☐ No ☐

Has any member of your family had orthodontic treatment? Yes ☐ No ☐

Did any family member's orthodontic treatment include jaw surgery or tooth extractions? Yes ☐ No ☐

Yes	No	?	
☐	☐	☐	Has your child ever experienced any complications following dental treatment?
☐	☐	☐	Is your child currently having any dental treatment or had a filling in the last year?
☐	☐	☐	Is your child being teased at school bercause of his/her teeth?
☐	☐	☐	Has your child ever had instructions in proper brushing technique?
☐	☐	☐	Do your child's gums bleed when brushed?
☐	☐	☐	Has your child ever injured his/her jaws, face or teeth?
☐	☐	☐	Does your child have any other dental problems?

Has your child had previous orthodontic consultations or treatment? Yes ☐ No ☐

If yes - please explain

PATIENT CONSENT

Privacy of your personal health information is an important part of our office's providing you with quality dental care. We understand the importance of protecting your personal health information. We are committed to collecting, using and disclosing your personal health information responsibly. We also try to be as open and transparent as possible about the way we handle your personal health information. It is important to us to provide this service to our patients.

In this office, Dr. Doug Ford is the contact person for personal health information related matters. All staff members who come into contact with your personal health information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

- Only necessary information is collected about you.
- We only share your information with your consent.
- Storage, retention and destruction of your personal health information complies with existing legislation, and privacy protection protocols.
- Our privacy protocols comply with ADA standards.

Do not hesitate to discuss our policies with Dr. Ford or any member of our office staff. By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal health information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal health information, we will seek your approval in advance.

☐ To the best of my knowledge, the above information is correct. If there is a change in my child's health history, or his/her medications change, I will inform the orthodontist at the next appointment.

☐ When appropriate or necessary, the orthodontist may send and discuss my child's health information with other involved health professionals.

Form Submission Date*

Signature*

Additional Comments/Notes

SEND

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