CARTWRIGHT
ORTHODONTICS
BOARD-CERTIFIED ORTHODONTIST

Child Health History Form

Welcome to our office! In order for us to provide you with the best possible treatment, we would like you to provide us with the following information. Thank you!

PATIENT INFORMATION

Name_____ Nickname_____ Sex_____ Birth Date_____
Address_____ Home Phone _____ Cell Phone_____
Email Address:_____
City_____ State____ Zip_____ Name of School_____

The following information is required for insurance purposes:

Father's Name_____
Address (If different from child's):
Street_____
City_____ State_____ Zip_____
Home Phone_____
Cell Phone_____
Employer_____
Work Phone_____

Mother's Name_____
Address (If different from child's):
Street_____
City_____ State_____ Zip_____
Home Phone_____
Cell Phone_____
Employer_____
Work Phone_____

At which phone number should messages be left?_____
Whom may we thank for referring your to our office?
( ) Family Dentist ( ) Relative ( ) Friend/Neighbor ( ) Other:_____
Name:_____

FINANCIAL INFORMATION

Who is responsible for payment?_____
Does the responsible party have orthodontic insurance? ( )Yes ( )No
IF YES, PLEASE COMPLETE THE FOLLOWING:
Name of insurance company_____ Address_____
Subscriber's Name_____ Relationship to patient_____
Social Security Number _____ Birth Date _____
Is there secondary insurance? ( ) Yes ( ) No
Name of Insurance company_____ Address_____
Subscriber's Name_____ Relationship to patient_____
Social Security Number _____ Birth Date _____

Please complete medical & dental information on the following page.

HEALTH HISTORY

DATE_____

Dentist's Name_____ **Date of Last Visit_____**

Physician's Name_____ **Date of Last Visit_____**

Place a mark on "Yes" or "No" to indicate if you have any of the following:

AIDS	__Yes __No	Epilepsy	__Yes __No	Psychiatric Care	__Yes __No
Anemia	__Yes __No	Fainting or dizziness	__Yes __No	Radiation Treatment	__Yes __No
Arthritis, Rheumatism	__Yes __No	Glaucoma	__Yes __No	Respiratory Disease	__Yes __No
Artificial Heart Valves	__Yes __No	Headaches	__Yes __No	Rheumatic Fever	__Yes __No
Artificial Joints	__Yes __No	Heart Murmur	__Yes __No	Scarlet Fever	__Yes __No
Asthma	__Yes __No	Heart Problems	__Yes __No	Shortness of Breath	__Yes __No
Back Problems	__Yes __No	Hepatitis	__Yes __No	Sinus Trouble	__Yes __No
Bleeding abnormally		Type_____		Skin Rash	__Yes __No
with extractions or		Herpes	__Yes __No	Special Diet	__Yes __No
surgery	__Yes __No	High Blood Pressure	__Yes __No	Stroke	__Yes __No
Blood Disease	__Yes __No	HIV Positive	__Yes __No	Swelling of feet or	
Cancer	__Yes __No	Jaundice	__Yes __No	ankles	__Yes __No
Chemical Dependency	__Yes __No	Jaw Pain	__Yes __No	Swollen Neck Glands	__Yes __No
Chemotherapy	__Yes __No	Kidney Disease	__Yes __No	Thyroid Problems	__Yes __No
Circulatory Problems	__Yes __No	Liver Disease	__Yes __No	Tonsillitis	__Yes __No
Congenital Heart Lesions	__Yes __No	Low Blood Pressure	__Yes __No	Tuberculosis	__Yes __No
Cortisone Treatments	__Yes __No	Mitral Valve Prolapse	__Yes __No	Tumor or growth on	
Cough, persistent or		Nervous Problems	__Yes __No	head or neck	__Yes __No
Bloody	__Yes __No	Pacemaker	__Yes __No	Ulcer	__Yes __No
Diabetes	__Yes __No	Women:		Venereal Disease	__Yes __No
Emphysema	__Yes __No	Are you pregnant?	__Yes __No	Weight Loss,	
Do you wear		Due Date_____		unexplained	__Yes __No
contact lenses?	__yes __No	Are you nursing?	__Yes __No		

1. Does the patient experience any difficulty chewing or swallowing food? ___Yes ___No
2. Has the patient had any injuries involving the teeth or jaws? ___Yes ___No
   If yes, please explain:_____
3. Does the patient experience any clicking of jaw pain when opening or closing the mouth? ___Yes ___No
   If yes, please explain:_____
4. Is the patient a mouth breather? ___Yes ___No
5. Is the patient a snorer? ___Yes ___No
6. Does/did the patient have any thumb or finger-sucking habits? ___Yes ___No
   Any other habits? _____ To what age?_____
7. Has the patient had a previous orthodontic consult or treatment? ___Yes ___No
   If yes, please explain:_____
8. Do other family members have a similar problem? ___Yes ___No
9. Main reason for seeking orthodontic treatment: Function ___ Appearance ___ Referred by dentist___
   Explain if necessary:_____
10. If referred by your family dentist, please describe his or her concerns as explained to you
    _____
11. Does the patient need to be pre-medicated with an antibiotic for any dental procedures? ___Yes ___No

MEDICATIONS

List medications you are currently taking:

_____

Pharmacy Name:_____

Pharmacy Phone:_____

ALLERGIES

__Latex __Food (please list)_____

__Nickel __Other_____

__Mint

Parent's/Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____