CHILD HEALTH HISTORY

The better we communicate, the better we can care for you. To help us meet all of your orthodontic needs, please fill out this form completely.

SLOSS & CARPENTER ORTHODONTICS

About Your Child

Name: _____ Nickname: _____

Male ☐ Female ☐ Birth date:_____Age: _____

School:_____Grade: _____

Home Address: _____

_____

Who Is Accompanying Your Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Parents Marital Status: Single Married Divorced

Title: _____Mother's Name: _____

Birth Date: _____ Cell #: _____

Address: _____

Email: _____ SS #: _____

Title: ____Father's Name: _____

Birth Date: _____ Cell #: _____

Address: _____

Email: _____ SS #: _____

Referred by: _____

Orthodontic Insurance

PRIMARY INSURANCE

Insurance Co. Name:_____

Insurance Co. Address:_____

City, State, Zip:_____

Insurance Co. Phone #: _____

Insured's Name:_____Relation:_____

Insured's Birth date:_____Group #:_____

Insured's ID or SSN #:_____

SECONDARY INSURANCE

Insurance Co. Name:_____

Insurance Co. Address:_____

City, State, Zip:_____

Insurance Co. Phone #: _____

Insured's Name:_____Relation:_____

Insured's Birth date:_____Group #:_____

Insured's ID or SSN #:_____

Billing Party

Name:_____

Male ☐ Female ☐ Birth date:_____Age:_____

Billing Address: _____

E-mail Address: _____

Driver's License #: _____ SSN: _____

Cell #:_____Home #:_____

Work #:_____Extension:_____

Employer:_____

How long there?_____Occupation:_____

Medical History

Child's Physician: _____

Date of Last Visit: _____ Phone #: _____

Medications your child is taking: _____

_____

Medications your child is allergic to: _____

_____

Is your child allergic to any of the following materials?

Plastic Latex Metal

Please list any other material your child is allergic to: _____

_____

Please describe your child's current health:

Good ☐ Fair ☐ Poor ☐

Has puberty begun? Yes ☐ No ☐

Continued on next page

Medical History (Continued)

Does your child have sleep apnea? Yes ☐ No ☐

Have adenoids and tonsils removed? Yes ☐ No ☐

Has your child had any of the following medical issues?

	Y	N		Y	N
Abnormal Bleeding			Hepatitis		
ADHD			Herpes		
Anemia			High Blood Pressure		
Arthritis			HIV+/AIDS		
Artificial Bone(s), joint(s) or valve(s)					
Asthma			Kidney Problems		
Autism Spectrum			Liver Disease		
Blood Transfusion			Low Blood Pressure		
Cancer			Lupus		
Chemotherapy			Mitral Valve Prolapse		
Cleft Lip/Palate					
Colitis			Prolapse		
Congenital Heart Defect			Pacemaker		
Diabetes			Psychiatric Problems		
Emphysema			Radiation Treatment		
Epilepsy			Rheumatic Fever		
Fainting Spells			Scarlet Fever		
Fever Blisters			Seizures		
Frequent Headaches			Sensory Processing Disorder		
Glaucoma			Shingles		
Handicaps/ Disabilities			Sickle Cell Disease		
Hay Fever			Stroke		
Hearing Impairment			Thyroid Problems		
Heart Attack			Tuberculosis		
Heart Surgery			Ulcer		
Hemophilia			STI's		

Other medical issues: _____

Is pre-treatment medication necessary such as antibiotic prophylaxis? Yes or No

Does your child have any of the following habits?

Thumb/ Finger Sucking	Y	N
Lip Sucking/ Biting	Y	N
Clenching/ Grinding Teeth	Y	N
Mouth Breathing	Y	N
Speech Problems	Y	N
Nail Biting	Y	N

Dental History

What are the main orthodontic concerns? _____

_____

Dentist Name: _____

Last Visit Date: _____

Has your child ever been evaluated or had orthodontic treatment before? Y N

Have there been any injuries to the face, mouth, teeth or chin? Y N

List any musical instruments played: _____

Has your child been informed of any missing or extra permanent teeth? Y N

Does your child brush his/her teeth daily? Y N

Floss his/her teeth daily? Y N

Has your child ever had any pain/ tenderness in his/her jaw joint (TMJ/TMD)? Y N

If yes please explain: _____

Authorizations

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

Signature Date

I certify that I am covered by _____ Insurance Co. and I assign directly to Sloss & Carpenter Orthodontics all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submission, whether manual or electric.

Signature Date

PAYMENT IS DUE AT THE TIME OF SERVICE

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

SLOSS & CARPENTER
ORTHODONTICS

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization.
In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING PROVIDERS / FACILITIES IN THE FUTURE.

_____ _____
Please ***print*** your name Please ***sign*** your name

If Patient is a minor:

_____ _____
Parent/Guardian name (please print) Parent/Guardian (please ***sign*** your name)

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.