Health History Questionnaire

(PATIENTS UNDER 18 YEARS OLD)

Date _____

Patient Information

Last Name_____First _____ Middle _____
Patient prefers to be called_____ Birth Date_____ Age _____ ❍ Male ❍ Female
Address _____ City_____ Zip _____
Best Phone_____Patient interests/hobbies/sports _____
Patient grade_____ Patient height _____ Birth father height_____Birth mother height _____
Sibling names/ages_____ Family/friends treated here _____
Whom may we thank for recommending us?_____ Dentist name _____
What is the primary concern for Dr. Bourne to address?_____

Father/Guardian

Last name _____First _____ Middle _____
Address _____ City _____ Zip _____
Years there_____ SSN _____ Birth date_____Relationship to patient _____
Cell Phone_____ Email_____ Home _____ Work _____
Previous address (if less than 3 years at present address) _____
Employer _____ Position _____ Years there_____

Mother/Guardian

Last name _____First _____ Middle _____
Address _____ City _____ Zip _____
Years there_____ SSN _____ Birth date_____Relationship to patient _____
Cell Phone_____ Email_____ Home_____ Work _____
Previous address (if less than 3 years at present address) _____
Employer _____ Position _____ Years there_____

Orthodontic Insurance Information

Primary policy holder name _____ SSN/ID# _____Birth Date _____
Insurance company_____ Group number _____Phone number_____
Secondary policy holder name _____ SSN/ID# _____ Birth Date_____
Insurance company_____ Group number_____ Phone number _____

Dental History

Dentist _____ City_____Date of last visit _____
Has patient been examined/treated by an orthodontist previously? _____
How would you describe the patient's attitude towards orthodontic treatment?_____

OVER

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Please check any of the following if the patient has/has had:

❍ Injuries to the face/mouth/teeth
❍ Thumb, finger, or lip sucking
❍ Tongue thrusting
❍ Speech difficulties
❍ Missing or extra permanent teeth
❍ Teeth removed by extraction
❍ Clenching or grinding
❍ Other_____
❍ Jaw joint sounds or pain/TMJ
❍ Family history of jaw-size unbalance
❍ Previous difficulty w/dental treatment

Medical History

Physician _____ City _____ Phone _____

Medications currently being taken_____

Medication allergies_____ **Is the patient allergic to latex?** ❍ Yes ❍ No

Other allergies _____

Hospitalizations? Please list procedures and dates _____

Females: Has menstruation began? ❍ Yes ❍ No If so, when? _____ Is the patient pregnant? ❍ Yes ❍ No

Has the patient had any recent rapid growth? ❍ Yes ❍ No If so, how much?_____

Please check any of the following if the patient has/has had:

❍ Abnormal bleeding
❍ Anemia
❍ Arthritic/Rheumatoid conditions
❍ Artificial joints/valves/implants
❍ Asthma/respiratory problems
❍ ADHD/sensory problems
❍ Birth defects/hereditary issues
❍ Cardiovascular problems
❍ Cancer/tumor
❍ Diabetes
❍ Dizziness/fainting
❍ Ear/nose/throat/eye issues
❍ Eating disorders
❍ Endocrine/thyroid problems
❍ Epilepsy
❍ Frequent headaches
❍ Gastrointestinal disorders
❍ Heart murmur
❍ Hepatitis/liver problems
❍ Herpes
❍ High blood pressure
❍ HIV/AIDS
❍ Immune system problems
❍ Kidney problems
❍ Mental/emotional problems
❍ Nervous system disorders
❍ Radiation/chemotherapy
❍ Rheumatoid disorders
❍ Tuberculosis
❍ Vision/hearing problems
❍ Other_____

Sleep/Airway Issues

Does the patient tend to be a mouth-breather? ❍ Yes ❍ No
Does the patient seem rested in the morning? ❍ Yes ❍ No
Is the patient often sleepy during the day? ❍ Yes ❍ No
Does the patient often snore at night? ❍ Yes ❍ No
Does the patient sleep-walk or have night terrors? ❍ Yes ❍ No
Has the patient seen an Ear,Nose&Throat specialist? ❍ Yes ❍ No

Treatment Motivation

Orthodontic treatment can improve the overall appearance of patients' teeth and faces. Please help us to understand your family's wishes regarding orthodontic treatment by indicating any of the following that may apply:

How would you like the patient's teeth to change?

❍ Straighten teeth ❍ upper ❍ lower
❍ Move upper teeth ❍ forward ❍ backward
❍ Move lower teeth ❍ forward ❍ backward
❍ Move midline of the upper teeth ❍ left ❍ right
❍ Move midline of the lower teeth ❍ left ❍ right
❍ Move upper teeth up (teeth and gums show too much)
❍ Move upper teeth down (teeth and gums show too little)

If you would you like the patient's face to change, how so?

❍ Move upper lip ❍ forward ❍ backward
❍ Move lower lip ❍ forward ❍ backward
❍ Move upper jaw ❍ forward ❍ backward
❍ Move lower jaw ❍ forward ❍ backward
❍ Move chin to center it ❍ left ❍ right
❍ Other changes desired _____

I have read and understand the above questions. I will not hold the orthodontist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form. It is my responsibility to inform this practice of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees, and may, at the discretion of this practice, use the services of one or more credit reporting services. If this practice accepts insurance, I understand that I am responsible for payment of services rendered and for paying any co-payment and deductibles that my insurance does not cover.

Signed (parent/guardian)_____ **Date** _____