Anderson Orthodontics

Child Health History

ABOUT YOUR CHILD

Child's Name: _____ Birthdate: ____/____/_____ ☐ Male ☐Female

Prefers to be called: _____ Home Address: _____

Patient lives with: _____ City: _____St: _____ Zip: _____

Phone: ( )_____ □ Home □ Cell Parent Email: _____

Other family members seen by us: _____

How did you hear about us: _____

Emergency Contact:_____

Relation: _____ Phone: ( )_____

ACCOUNT INFORMATION

Name: _____ Relation to patient: _____

Birthdate:_____/_____/_____ ☐Married ☐Single ☐Divorced ☐Widowed

Phone: ( )_____ □ Home □ Cell Work Phone: ( )_____

Employer: _____ Occupation:_____

SPOUSE:

Name: _____ Relation to patient: _____

Birthdate:_____/_____/_____

Phone: ( )_____ □ Home □ Cell Work Phone: ( )_____

Employer: _____ Occupation:_____

DENTAL INSURANCE

Policy Holder: _____ Relation to patient: _____

Policy holder Birthdate: ____/____/_____ Policy holder Employer: _____

Insurance Company: _____ Insurance Phone: _____

ID#: _____SSN:_____ Group #: _____

I hereby authorize payment directly to Dr. Eric Anderson DMD, unless otherwise stated. I understand I am responsible for any charges not covered by my insurance company.

_____ _____/_____/_____

Signature Date

CONSENT

I consent to records to be taken as part of the consult process. These may include radiographs and photos. This information is used in our office as part of the treatment process. It can also be used to communicate with other providers or insurance companies.

_____ _____/_____/_____

Signature Date

HEALTH HISTORY

	Yes	No
Is the patient being treated by a physician at this time?	☐	☐
Has the patient ever been hospitalized?	☐	☐
Does your child have any allergies: _____	☐	☐
Is your child taking any medications: _____	☐	☐
Does your child suck his/her thumb, finger or pacifier?	☐	☐
Is your child adopted	☐	☐

Has the patient ever been diagnosed as having any of the following conditions?

	Yes	No		Yes	No
Arthritis	☐	☐	Heart Disease	☐	☐
Asthma	☐	☐	Hepatitis	☐	☐
Bleeding Problems	☐	☐	HIV or AIDS	☐	☐
Cancer	☐	☐	Liver Disease	☐	☐
Cleft Lip/Palate	☐	☐	Vision/Hearing	☐	☐
Diabetes	☐	☐	Heart Issues	☐	☐
Epilepsy	☐	☐	Other _____		

DENTAL HISTORY

Dentist_____ Date of Last Visit_____

How often do you brush per day: ☐1X ☐2X ☐3X ☐4+
Do you floss? ☐Yes ☐No

Areas of Concern (Circle all that apply):

Crowding	Missing/Extra teeth	Cross-bite	Speech Problems
Crooked Teeth	Overbite	Late Eruption	Jaw Problems

History of the following (Circle all that apply):

Trauma to Teeth/Face	Mouth breathing	Snoring	Tongue Thrust
Grinding/Clenching	Headaches/Earaches	Previous orthodontic treatment	

Family history of bite problems (Explain)

_____

Is there anything we should know about your child?

_____

_____

_____ _____ _____

Signature of parent/guardian Date Doctor Signature