



Child Form

WELCOME to Quimby and Collins Orthodontics! We are pleased that you contacted our office for an orthodontic evaluation. Please complete the questionnaire and bring it with you to your appointment.

**Patient's Name:** Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Gender \_\_\_\_\_  
 Birth Date \_\_\_\_\_ Age \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_  
**Email address for reminder emails:** \_\_\_\_\_

**Mother** \_\_\_\_\_ Birth date \_\_\_\_\_ SSN \_\_\_\_\_ Marital Status \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work/Cell \_\_\_\_\_ May we contact you at work? \_\_\_\_\_  
 Employer \_\_\_\_\_ Position \_\_\_\_\_

**Father** \_\_\_\_\_ Birth date \_\_\_\_\_ SSN \_\_\_\_\_ Marital Status \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work/Cell \_\_\_\_\_ May we contact you at work? \_\_\_\_\_  
 Employer \_\_\_\_\_ Position \_\_\_\_\_

**Who would like to be contacted initially in case of an emergency?**  
 (Please list name, phone number and relationship to patient for emergency contact) \_\_\_\_\_

**If your insurance pays the provider directly we will gladly submit the insurance for you. All requested information must be completed in order to submit to your insurance. Please bring verification of your insurance to your consultation. If your insurance pays the subscriber, we will provide you with the insurance claim forms for your submission. We will not accept this insurance.**

**SUBSCRIBER'S NAME** \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
 SSN/ID# \_\_\_\_\_ DOB \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
**Employer** \_\_\_\_\_ Position \_\_\_\_\_  
 Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Dental Insurance Co. \_\_\_\_\_ Phone \_\_\_\_\_ ID# \_\_\_\_\_  
 Insurance Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Health History Questionnaire**

Family physician name \_\_\_\_\_ Date of your last visit to this physician \_\_\_\_\_  
 Date of last complete physical exam \_\_\_\_\_ Examining doctor's name \_\_\_\_\_  
 What is your approximate height? \_\_\_\_\_ ft \_\_\_\_\_ in. What is your approximate weight? \_\_\_\_\_ lbs.

History:	YES	NO	History:	YES	NO	History:	YES	NO
Nose/Sinus	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco use	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	HIVpositive/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Smoking	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries	<input type="checkbox"/>	<input type="checkbox"/>	Phen-fen use	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Redux use	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Any drug use	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes/Blood Sugar	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>			
Chronic Disease	<input type="checkbox"/>	<input type="checkbox"/>	Allergic Reactions	<input type="checkbox"/>	<input type="checkbox"/>			
Panic Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>			
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>			
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>						

**If YES is checked, please list the specific problem(s):** \_\_\_\_\_  
 \_\_\_\_\_  
**Please list current medications:** \_\_\_\_\_  
 \_\_\_\_\_

**Child Information:**

Has a physician indicated that the patient is maturing? If so, check the appropriate response:  
 \_\_\_\_\_ normally, \_\_\_\_\_ earlier than normal, \_\_\_\_\_ later than normal?  
 If female, has she started menstruation? \_\_\_\_\_ If male, has his voice changed? \_\_\_\_\_ @ what age? \_\_\_\_\_

**Females:**

Are you pregnant now or do you think you may be? \_\_\_ Do you anticipate becoming pregnant? \_\_\_\_\_

**Dental History:**

Name of your family dentist: \_\_\_\_\_ Date of your last visit: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**Today's chief concern:** \_\_\_\_\_

History of:	YES	NO	
Tooth injury	<input type="checkbox"/>	<input type="checkbox"/>	Chipped __ Broken __ Lost __
Jaw injury	<input type="checkbox"/>	<input type="checkbox"/>	Age __
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	Usually __ Sometimes __ Rarely __ When: __ Brushing __ Flossing __ Eating
Oral disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers __ Sores __ Cancer __
Grinding teeth	<input type="checkbox"/>	<input type="checkbox"/>	During the day __ During the night __
Clenching teeth	<input type="checkbox"/>	<input type="checkbox"/>	During the day __ During the night __
Oral habits	<input type="checkbox"/>	<input type="checkbox"/>	Thumb sucking __ Finger sucking __ Tongue thrusting __ Nail biting __
Jaw joint pain	<input type="checkbox"/>	<input type="checkbox"/>	Right TMJ: __ Constant __ Periodic When you: __ chew __ talk __ open __ close Left TMJ: __ Constant __ Periodic When you: __ chew __ talk __ open __ close
Jaw joint noises	<input type="checkbox"/>	<input type="checkbox"/>	Right: __ clicking __ popping __ grating __ Left: __ clicking __ popping __ grating __
Jaw joint locking	<input type="checkbox"/>	<input type="checkbox"/>	Right: __ when open __ when closed __ Left: __ when open __ when closed __

Have you had:	Yes	NO	Explain Treatment	Date	Doctor
Periodontal treatment?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Endodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Oral Surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Prosthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

**FACTS ABOUT YOU**

Do you sing? \_\_\_\_\_ Play instruments? List \_\_\_\_\_ Play sports? List \_\_\_\_\_

Siblings and Ages \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

What else would you like us to know about you? \_\_\_\_\_

I hereby certify that I have reviewed the above medical and dental history. I agree it is, to the best of my knowledge, accurate at this time. If there are any future changes in this information I will inform the practice of these changes.

Signature of person filling out this health history form \_\_\_\_\_ Date \_\_\_\_\_

Signature of doctor who reviewed this form \_\_\_\_\_ Date \_\_\_\_\_