



Child Form
2020

Initial Form Reviewed By: _____
Final Review of Form By: _____

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 _____ School & Grade _____
 Address _____ City _____ State _____ Zip _____

Mother _____ Birth date _____ SSN _____ Marital Status _____
 Address _____ City _____ State _____ Zip _____
 Employer _____ Position _____
Father _____ Birth date _____ SSN _____ Marital Status _____
 Address _____ City _____ State _____ Zip _____
 Employer _____ Position _____

List of phone numbers you can be reached (in order of preference):

Name: _____ Number: _____
 Name: _____ Number: _____

Email address for reminder emails (we do not call):

Phone number for text reminders:

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"/>	Operations	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	HIVpositive/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries	<input type="checkbox"/>	<input type="checkbox"/>	Any drug use	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes/Blood Sugar	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Disease	<input type="checkbox"/>	<input type="checkbox"/>	Allergic Reactions	<input type="checkbox"/>	<input type="checkbox"/>	Tonsil/Adenoid Condition	<input type="checkbox"/>	<input type="checkbox"/>
Panic Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<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):

Medications:

Taken For:

Please list any known allergies:

Aspirin Penicillin Latex Ibuprofen Sulfate Metal Foods
 Other: _____

Turn over

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? _____ at 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? _____

What is your primary concern? Why are you here? _____

Questions: _____

Now or in the past, has the patient had:

YES NO

- Permanent or "extra" (supernumerary) teeth removed?
- Supernumerary (extra) or congenitally missing teeth?
- Chipped or otherwise injured primary (baby) or permanent teeth?
- Teeth sensitive to hot/cold; teeth that throb or ache?
- Jaw fractures, cysts or mouth infections?
- "Dead teeth" or root canals treated?
- Bleeding gums, bad taste or mouth odor
- Periodontal "gum problems"?
- "Gum boils", frequent canker sores or cold sores?
- Thumb, finger, or sucking habit? Until what age?
- Abnormal swallowing habit (tongue thrusting)?
- History of speech problems?
- Mouth breathing habit, snoring or difficulty in breathing?
- Tooth grinding or jaw clenching?
- Any pain, clicking or locking in jaw or ringing in ears?

YES NO

- Any pain or soreness in the muscles of the face or around the ears?
- Difficulty in chewing or jaw opening?
- Have you ever been treated for "TMD" or "TMJ" problems?
- Aware of loose, broken or missing restorations (fillings)?
- Any teeth irritating cheek, lip, tongue or palate?
- Concerned about spaced, crooked or protruding teeth?
- Aware or concerned about under or over developed jaw?
- Any relative with similar tooth or jaw relationships?
- Any wisdom tooth problems?
- Had any periodontal (gum) treatment?
- Had any serious trouble associated with any previous dental treatment?
- Been under another dentist's care?
Specialist _____
Other _____
- Ever had a prior orthodontic examination or treatment?
- Would you object to wearing orthodontic appliances (braces) should they be indicated?

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 _____