QUIMBY & COLLINS
O-R-T-H-O-D-O-N-T-I-C-S

Child Form

Identification Checked: ☐

Form Reviewed 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 _____
Address _____City _____State _____ Zip _____
Home Phone _____ School _____ Grade _____
Email address for reminder emails (we do not call):

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	☐	☐	Hepatitis	☐	☐	Tobacco use	☐	☐
Asthma	☐	☐	HIVpositive/AIDS	☐	☐	Smoking	☐	☐
Breathing Disorder	☐	☐	Surgeries	☐	☐	Phen-fen use	☐	☐
Heart Murmur	☐	☐	Epilepsy	☐	☐	Redux use	☐	☐
High Blood Pressure	☐	☐	Kidney Disease	☐	☐	Any drug use	☐	☐
Rheumatic Fever	☐	☐	Diabetes/Blood Sugar	☐	☐	Osteoporosis	☐	☐
Endocrine	☐	☐	Blood Disorders	☐	☐			
Chronic Disease	☐	☐	Allergic Reactions	☐	☐			
Panic Disorders	☐	☐	Thyroid Problems	☐	☐			
Cancer	☐	☐	Radiation Therapy	☐	☐			
Tuberculosis	☐	☐						

If YES is checked, please list the specific problem(s):

Please list current medications:

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Child Form

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? _____
Today's chief concern: _____

History of:	**YES**	**NO**	
Tooth injury	☐	☐	Chipped __ Broken__ Lost__
Jaw injury	☐	☐	Age __
Bleeding gums	☐	☐	Usually ___ Sometimes __ Rarely __ When: __Brushing __Flossing __Eating
Oral disease	☐	☐	Ulcers __ Sores__ Cancer __
Grinding teeth	☐	☐	During the day __ During the night__
Clenching teeth	☐	☐	During the day __ During the night__
Oral habits	☐	☐	Thumb sucking __ Finger sucking __ Tongue thrusting __ Nail biting __
Jaw joint pain	☐	☐	Right TMJ: ___Constant ___ Periodic When you: __ chew __talk __ open __ close Left TMJ: ___ Constant ___ Periodic When you: __ chew __talk __ open __ close
Jaw joint noises	☐	☐	Right: ___ clicking ___ popping ___ grating ___ Left: ___ clicking ___ popping ___ grating ___
Jaw joint locking	☐	☐	Right: ___when open ____when closed ____ Left: ___ when open ____when closed ____

Have you had:	**Yes**	**NO**	**Explain Treatment**	**Date**	**Doctor**
Periodontal treatment?	☐	☐	_____	_____	_____
Orthodontic treatment?	☐	☐	_____	_____	_____
Endodontic treatment?	☐	☐	_____	_____	_____
Oral Surgery?	☐	☐	_____	_____	_____
Prosthodontic treatment?	☐	☐	_____	_____	_____

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_____