QUIMBY & COLLINS
ORTHODONTICS

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	☐	☐	Hepatitis	☐	☐	Operations	☐	☐
Asthma	☐	☐	HIVpositive/AIDS	☐	☐	Hospitalizations	☐	☐
Breathing Disorder	☐	☐	Surgeries	☐	☐	Any drug use	☐	☐
Heart Murmur	☐	☐	Epilepsy	☐	☐	Osteoporosis	☐	☐
High Blood Pressure	☐	☐	Kidney Disease	☐	☐	Stomach Ulcer	☐	☐
Rheumatic Fever	☐	☐	Diabetes/Blood Sugar	☐	☐	Headaches	☐	☐
Endocrine	☐	☐	Blood Disorders	☐	☐	Skin Disorder	☐	☐
Chronic Disease	☐	☐	Allergic Reactions	☐	☐	Tonsil/Adenoid Condition	☐	☐
Panic Disorders	☐	☐	Thyroid Problems	☐	☐	Headaches	☐	☐
Cancer	☐	☐	Radiation Therapy	☐	☐	Tuberculosis	☐	☐

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 ⇨

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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		YES	NO	
☐	☐	Permanent or "extra" (supernumerary) teeth removed?	☐	☐	Any pain or soreness in the muscles of the face or around the ears?
☐	☐	Supernumerary (extra) or congenitally missing teeth?	☐	☐	Difficulty in chewing or jaw opening?
☐	☐	Chipped or otherwise injured primary (baby) or permanent teeth?	☐	☐	Have you ever been treated for "TMD" or "TMJ" problems?
☐	☐	Teeth sensitive to hot/cold; teeth that throb or ache?	☐	☐	Aware of loose, broken or missing restorations (fillings)?
☐	☐	Jaw fractures, cysts or mouth infections?	☐	☐	Any teeth irritating cheek, lip, tongue or palate?
☐	☐	"Dead teeth" or root canals treated?	☐	☐	Concerned about spaced, crooked or protruding teeth?
☐	☐	Bleeding gums, bad taste or mouth odor	☐	☐	Aware or concerned about under or over developed jaw?
☐	☐	Periodontal "gum problems"?	☐	☐	Any relative with similar tooth or jaw relationships?
☐	☐	"Gum boils", frequent canker sores or cold sores?	☐	☐	Any wisdom tooth problems?
☐	☐	Thumb, finger, or sucking habit? Until what age?	☐	☐	Had any periodontal (gum) treatment?
☐	☐	Abnormal swallowing habit (tongue thrusting)?	☐	☐	Had any serious trouble associated with any previous dental treatment?
☐	☐	History of speech problems?	☐	☐	Been under another dentist's care? Specialist _____ Other _____
☐	☐	Mouth breathing habit, snoring or difficulty in breathing?	☐	☐	Ever had a prior orthodontic examination or treatment?
☐	☐	Tooth grinding or jaw clenching?	☐	☐	Would you object to wearing orthodontic appliances (braces) should they be indicated?
☐	☐	Any pain, clicking or locking in jaw or ringing in ears?			

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_____