Jones Orthodontics

MEDICAL INFORMATION FORM

ABOUT YOUR CHILD

Name (Last, First, MI) _____

Nickname _____

Birthdate _____ Age _____ ☐ Male ☐ Female

School _____ Grade _____

Hobbies/Sports/Activities _____

Address _____

City _____ State _____ Zip _____

Phone (_____) _____

General Dentist _____

Last Visit Date _____

Mother Name _____

Father Name _____

Brother/Sister's Name/Age _____

Brother/Sister's Name/Age _____

Brother/Sister's Name/Age _____

Brother/Sister's Name/Age _____

Lives With _____

Relationship _____ Has legal custody? ☐ Yes ☐ No

Whom may we thank for referring you? _____

FINANCIALLY RESPONSIBLE PARTY

Name (Last, First, MI) _____

Address (If different) _____

City _____ State _____ Zip _____

Primary Phone (_____) _____

Other Phone (_____) _____

E-Mail _____

Birthdate _____ Employer _____

ORTHODONTIC INSURANCE ☐ Yes ☐ No

Insured's Name _____ Birthdate _____

Policy/ID # _____ Group # _____

Insurance Company _____

Insured's Employer _____

DO YOU HAVE DUAL COVERAGE? ☐ Yes ☐ No

Insured's Name _____ Birthdate _____

Policy/ID # _____ Group # _____

Insurance Company _____

Insured's Employer _____

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MEDICAL HISTORY

Is your child currently under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

Is your child taking any prescription, over-the-counter or herbal medication?

☐ Yes ☐ No If yes, please list: _____

If female, has menstruation begun? ☐ Yes ☐ No

PLEASE INDICATE IF YOUR CHILD HAS OR HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS:

- ☐ Abnormal Bleeding
- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Artificial Bones/Joints
- ☐ Artificial Valves
- ☐ Asthma
- ☐ Arthritis/Rheumatism
- ☐ Canker/Cold Sores
- ☐ Cancer/Chemotherapy
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Drug/Alcohol Abuse
- ☐ Eating Disorders
- ☐ Epilepsy/Seizures
- ☐ Hearing Impairment
- ☐ Heart Disease/Surgery
- ☐ Hepatitis Type _____
- ☐ Herpes
- ☐ HIV/AIDS
- ☐ Hospitalized (for anything)
- ☐ Kidney Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Rheumatic/Scarlet Fever
- ☐ Severe/Frequent Headaches
- ☐ Sexually Transmitted Disease
- ☐ Sinus Problems
- ☐ Tuberculosis (TB)
- ☐ Transplants
- ☐ Ulcers/Colitis

Please list any other conditions that would be important for us to know:

_____

_____

IS YOUR CHILD ALLERGIC TO ANY OF THE FOLLOWING:

☐ Aspirin ☐ Penicillin ☐ Latex ☐ Metal/Plastics ☐ Codeine

☐ Sulphur ☐ Food ☐ Local Anesthetic ☐ Tetracycline

☐ Erythromycin ☐ Other _____

DENTAL HISTORY

Does your child pre-medicate before dental procedures? ☐ Yes ☐ No

If yes, please explain: _____

Has your child ever had an injury to his or her ☐ mouth ☐ teeth ☐ chin?

If yes, please explain: _____

Has your child had adenoids or tonsils removed? ☐ Yes ☐ No

If yes, please explain: _____

Does your child have any missing or extra permanent teeth? ☐ Yes ☐ No

If yes, please explain: _____

Does your child play any musical instruments? ☐ Yes ☐ No

If yes, please explain: _____

Has your child ever experienced pain/discomfort in his or her jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Has your child ever had experienced (please circle) clenching/grinding teeth; lip sucking/biting; mouth breathing; nail-biting; nursing/bottle habits; tongue thrust; thumb/finger sucking; speech problems?

If yes, please explain: _____

_____

Has an orthodontist been consulted previously? ☐ Yes ☐ No

If yes, please explain: _____

Has anyone in your family had orthodontic treatment? ☐ Yes ☐ No

If yes, please explain: _____

What are the main goals you would like orthodontics to accomplish?

_____

_____

SIGNATURE

I understand that the information that I have given is correct to the best of my knowledge. It will be held in the strictest of confidence per HIPPA regulations. It is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover.

_____ _____

Signature Date