Dental / Medical History
& General Information for CHILDREN

Jarrell Orthodontics

Please fill out both sides of form

Computer ID #: _____

Patient's General Info

Patient's Name: _____ Preferred Name: _____ Age: _____ Sex: M / F

Birth Date: _____ SS#: _____ Lives with: _____ Accompanied By: _____

Home Address: _____ City: _____ Zip: _____ Home Phone: (_____)_____

Cell Phone: (_____)_____ Pager #: (_____)_____ Email: _____

Emergency Contact: _____ Relation: _____ Phone #: (_____)_____

How did you hear about us? Referred by: ___ Your Dentist ___ Insurance ___ Web Site ___ Other: _____

Children in family (Name and Age): _____

School and Grade _____Other friends or relatives treated here? _____

Mother's Information Are parents Married____ Divorced ____ Separated ____ **Father's Information**

Name: _____ Hm #: (_____)_____ Name: _____ Hm #: (_____)_____

Address: _____ Address: _____

Employer: _____ Occupation: _____ Employer: _____ Occupation: _____

SS #: _____ Wk #: _____ SS #: _____ Wk #: _____

Pager/Cell: (_____)_____ Email: _____ Pager/Cell: (_____)_____Email:_____

Financial

Responsible Party for the Financial Account: ____ Mom ____ Dad ____ Guardian Name: _____ Other: _____

Address: _____ City: _____ Zip: _____ Phone: (_____)_____

SS#:_____ Birth Date: _____ IN D.L. #: _____

Do you have insurance with Orthodontic Coverage? Y / N **Are you planning on using Pre-Tax Dollar (Flex Plan)? Y / N**

Primary Dental Insurance Info

Insur. Co. name: _____ Tel #: (_____)_____

Address: _____

Insured Name: _____ Rel to Patient: _____

SS#: _____ Birthday: _____ Group/Plan ID:_____

Employer: _____ Max. Coverage: $_____

Secondary Dental Insurance Info

Insur. Co. name: _____ Tel #: (_____)_____

Address: _____

Insured Name: _____ Rel to Patient: _____

SS#: _____ Birthday: _____ Group/Plan ID:_____

Employer: _____ Max. Coverage: $_____

THIS BOX FOR OFFICE USE

Med/Dent Hx. Reviewed by: _____ Date: _____

Comments / Changes in Med/Dent Hx.								
Date Updated:								

==========Oral Health History of Patient==========

Dentist: _____ Dental Office Name: _____ Date of Last Check: _____

Address: _____ City: _____ Zip: _____ Phone: (_____)_____

What is your main Reason / Concern or Goal in seeking Orthodontic treatment now? _____ Dental Health _____ Cosmetics _____Dentist Referral _____ Other:

Please describe main concerns :_____

Have you ever had any Orthodontic treatment or consultations? Y / N If yes, please explain when and the outcome of the treatment: _____

_____

Does patient have any history of: (Please Circle)

Y / N Clicking or the Jaw Joints (TMJ)	Y / N Tongue thrusting / habit	Y / N Gum Problems
Y / N Pain in the Jaw Joints or Ears	Y / N Grinding teeth (Day / Night)	Y / N Extra Teeth
Y / N Injuries to the Teeth	Y / N Pen, lip or nail biting	Y / N Extraction of Teeth
Y / N Injuries to the Face	Y / N Thumb or Finger Sucking	Y / N Missing Teeth
Y / N Difficulty Chewing	Y / N Chewing Gum	Y / N Speech Problem
Y / N Fever Blisters / Ulcers	Y / N Mouth Breathing	Y / N Dry Mouth

If you have answered Yes to any of the above, please explain: _____

==========Medical History of Patient==========

Physician: _____ Are you under a physician's care presently? Y / N For What? _____

Address: _____ City: _____ Zip: _____ Phone: (_____)_____

Women: Are you Pregnant? Y / N Are you taking Birth Control pills? Y / N

Does patient have any history of: (Please Circle)

Y / N Heart Disease	Y / N Kidney Disease	Y / N Nasal blockage	Y / N Emotional Problem
Y / N Rheumatic Fever	Y / N Diabetes	Y / N Drug/Alcohol Use	Y / N Psychiatric Therapy
Y / N Heart Murmur	Y / N Seizures	Y / N Hepatitis / Jaundice	Y / N Digestive Disorder
Y / N High Blood Pressure	Y / N Asthma	Y / N Tuberculosis	Y / N Hospitalization / Surgery
Y / N AIDS / HIV +	Y / N Arthritis	Y / N Thyroid Disease	Y / N Blood / Bleeding Disorder
Y / N Heart Surgery	Y / N Artificial Bones / Joints	Y / N Frequent Colds	Y / N Unusual Childhood Disease
Y / N Artificial Valves	Y / N Cancer / Chemotherapy	Y / N Major Illnesses	Y / N Birth Defect

If you answered Yes to any of the above, please explain: _____

Are you taking ANY medications? Y / N Please list names and reasons: _____

Do you have ANY allergies? Y / N What? Penicillin / Aspirin / Codeine / Erythromycin / Dental Anesthetics / Food / Metals / Plastic / Latex / Other: _____

_____ Are you required to take antibiotics prior to Dental Visits? Y / N

Please give any other information which you feel may be of value in the treatment: _____

==========Consent==========

I hereby certify that I have filled out this form to the best of my knowledge and all the preceding answers are true and correct. I, the undersigned, further give full consent for performing any procedure, x-ray or exams deemed necessary for diagnosis and treatment recommended.

Parent / Guardian Signature _____ Date: _____ / _____ / _____