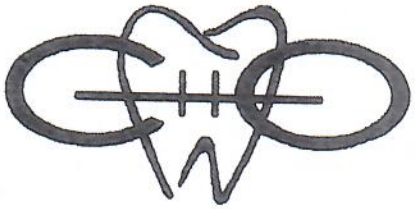

CHEEK-HILL
ORTHODONTICS

Child Medical History Form
(age 18 or younger)

PERSONAL INFORMATION

Date Today_____

Patient's Name: _____ Preferred Name: _____ Sex:_____

Home Address: _____ Date of Birth: _____

Home Phone: _____ Name of Family Physician: _____

Whom can we thank for referring you to this office?_____

If patient is already in orthodontic treatment, former orthodontist's name and address: _____

_____

Information For Patients Who Are MINORS

School: _____ Grade:_____

Interests: _____

What is the child's attitude toward: Brushing _____ Dentistry_____ Orthodontics _____

Parents' Marital Status: ❑ Married ❑ Separated ❑ Widowed ❑ Divorced If divorced, who has custody of child? _____

Responsible Party Information

Email Address:_____

Name _____

Residence _____

Mailing Address _____

How long at this address?_____ Home Phone_____ Work Phone_____

Previous Address (if less than 3 yrs.) _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone_____

MEDICAL HISTORY

Are you in good health? ❑ Yes ❑ No Reason: _____

Any major or unusual illnesses? ❑ Yes ❑ No Explain: _____

Currently under physician's care? ❑ Yes ❑ No Reason: _____

Currently taking medication? ❑ Yes ❑ No List: _____

Allergies ❑ Yes ❑ No List: _____

Drug sensitivity ❑ Yes ❑ No List: _____

Please Check Yes or No if the Patient Has Had Any of the Following:

YES	NO		YES	NO		YES	NO	
☐	☐	Anemia	☐	☐	Heart Disease	☐	☐	Frequent Colds or Flu
☐	☐	Blood Disease	☐	☐	Tuberculosis	☐	☐	Hearing Problems
☐	☐	Prolonged Bleeding	☐	☐	Diabetes	☐	☐	Tonsilitis/Adenitis
☐	☐	Hepatitis	☐	☐	Endocrine Problems	☐	☐	Tonsils Removed: Age:__
☐	☐	AIDS antibody positive	☐	☐	Bone Disorders	☐	☐	Adenoids Removed: Age:__
☐	☐	Jaundice	☐	☐	Epilepsy	☐	☐	Asthma
☐	☐	Rheumatic Fever	☐	☐	Herpes	☐	☐	Mouthbreathing: _
☐	☐	Kidney Disease				☐	☐	Emotional Problems

Growth Information for Patients Under 16 Years of Age

Father's Height _____ Mother's _____ Patient's _____ Adopted? ☐ Yes ☐ No

Patient Resembles: ☐ Neither Parent ☐ Mother ☐ Father

Girls: Has she started menstruation? ☐ No ☐ Yes When? _____

Boys: Has his voice changed? ☐ No ☐ Yes When? _____

Names and Ages of Patient's Brothers and Sisters? _____

Have any had Orthodontic Treatment? ☐ No ☐ Yes When? _____

DENTAL HISTORY

Name and address of patient's general dentist? _____

When did patient last see the dentist? _____

YES	NO	
☐	☐	Have you had any severe head or face injuries? Explain: _____
☐	☐	Have you had a history of thumb sucking or finger sucking? Stopped? _____
☐	☐	Do you play any musical (wind) instruments? What? _____
☐	☐	Have you consulted an orthodontist previously? _____
☐	☐	Have you had any previous orthodontic treatment? _____

YES	NO		YES	NO	
☐	☐	1. Do you have difficulty opening your mouth?	☐	☐	8. Have you had a recent injury to your head or neck?
☐	☐	2. Do you hear noises from the jaw joints?	☐	☐	9. Do you have arthritis?
☐	☐	3. Does your jaw get "stuck," "locked," or "go out"?	☐	☐	10. Do you have problems chewing, talking, or using your jaws?
☐	☐	4. Do you have pain in or about the ears, temples, or cheeks?	☐	☐	11. Do you clench or grind your teeth?
☐	☐	5. Do you have pain with chewing or yawning?	☐	☐	12. Have you been treated for a jaw joint (TMJ) problem? If so, when? _____
☐	☐	6. Does your bite feel uncomfortable or unusual?			
☐	☐	7. Do you have frequent headaches?			

Is there any other information that may be helpful? _____

Why are you seeking orthodontic consultation? _____

Person responsible for payment of account? _____

Do you have orthodontic insurance? _____ Insurance company _____

Do you have medical insurance? _____ Insurance company _____

I have read and received a copy of *Notice of Privacy Practices* _____ (PLEASE INITIAL)

This office will assist you in filing your insurance. Services rendered are charged to the patient, not the insurance company, and patients are expected to take care of their fees as services are rendered.

In separation/divorce situations, the individual who initiates services with us is held financially responsible. We do not bill another person or an estranged spouse unless that individual informs us in writing of his or her willingness to pay for services.

I understand that where appropriate, credit bureau reports may be obtained.

THANK YOU!

Signed, _____ Date: _____

CHEEK-HILL ORTHODONTICS

Adult Medical History Form

PERSONAL INFORMATION

Patient's Name: _____ Preferred Name: _____ Date Today_____

Home Address: _____ Sex:_____

Home Phone: _____ Date of Birth: _____

Whom can we thank for referring you to this office? _____ Name of Family Physician: _____

If patient is already in orthodontic treatment, former orthodontist's name and address: _____

_____

Responsible Party Information Email Address:_____

Name _____

Residence _____

Mailing Address _____

How long at this address?_____ Home Phone_____ Work Phone_____

Previous Address (if less than 3 yrs.) _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone_____

MEDICAL HISTORY

Are you in good health? ❑ Yes ❑ No Reason: _____

Any major or unusual illnesses? ❑ Yes ❑ No Explain: _____

Currently under physician's care? ❑ Yes ❑ No Reason: _____

Currently taking medication? ❑ Yes ❑ No List: _____

Allergies ❑ Yes ❑ No List: _____

Drug sensitivity ❑ Yes ❑ No List: _____

Please Check Yes or No if You Have Had Any of the Following:

YES	NO		YES	NO		YES	NO	
❑	❑	Anemia	❑	❑	Heart Disease	❑	❑	Frequent Colds or Flu
❑	❑	Blood Disease	❑	❑	Tuberculosis	❑	❑	Hearing Problems
❑	❑	Prolonged Bleeding	❑	❑	Diabetes	❑	❑	Tonsilitis/Adenitis
❑	❑	Hepatitis	❑	❑	Endocrine Problems	❑	❑	Tonsils Removed: Age:__
❑	❑	AIDS antibody positive	❑	❑	Bone Disorders	❑	❑	Adenoids Removed: Age:__
❑	❑	Jaundice	❑	❑	Epilepsy	❑	❑	Asthma
❑	❑	Rheumatic Fever	❑	❑	Herpes	❑	❑	Mouthbreathing: _
❑	❑	Kidney Disease				❑	❑	Emotional Problems

DENTAL HISTORY

Name of your general dentist? _____

When did you last see the dentist? _____

YES NO

❑ ❑ Have you had any severe head or face injuries? Explain: _____

❑ ❑ Have you had a history of thumb sucking or finger sucking? Stopped? _____

❑ ❑ Do you play any musical (wind) instruments? What? _____

❑ ❑ Have you consulted an orthodontist previously? _____

❑ ❑ Have you had any previous orthodontic treatment? _____

Please Respond to the Following:

YES NO

❑ ❑ 1. Do you have difficulty opening your mouth?
❑ ❑ 2. Do you hear noises from the jaw joints?
❑ ❑ 3. Does your jaw get ··stuck," "locked," or "go out"?
❑ ❑ 4. Do you have pain in or about the ears, temples, or cheeks?
❑ ❑ 5. Do you have pain with chewing or yawning?
❑ ❑ 6. Does your bite feel uncomfortable or unusual?
❑ ❑ 7. Do you have frequent headaches?

YES NO

❑ ❑ 8. Have you had a recent injury to your head or neck?
❑ ❑ 9. Do you have arthritis?
❑ ❑ 10. Do you have problems chewing, talking, or using your jaws?
❑ ❑ 11. Do you clench or grind your teeth?
❑ ❑ 12. Have you been treated for a jaw joint (TMJ) problem? If so, when? _____

Is there any other information that may be helpful? _____

Why are you seeking orthodontic consultation? _____

Person responsible for payment of account? _____

Do you have orthodontic insurance? _____ Insurance company _____

Do you have medical insurance? _____ Insurance company _____

I have read and received a copy of *Notice of Privacy Practices* _____ **(PLEASE INITIAL)**

This office will assist you in filing your insurance. Services rendered are charged to the patient, not the insurance company, and patients are expected to take care of their fees as services are rendered.

In separation/divorce situations, the individual who initiates services with us is held financially responsible. We do not bill another person or an estranged spouse unless that individual informs us in writing of his or her willingness to pay for services.

I understand that where appropriate, credit bureau reports may be obtained.
THANK YOU!

Signed, _____ Date: _____