CHILD MEDICAL HISTORY FORM
COLLINS ORTHODONTICS

800 Lakeway Dr. - Georgetown, TX 78628   (512) 863-6113

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Today's Date:__________________

Child's Name:______________________________________
Last First M. Ini.

Child's Birthdate: ____________________ Age _________

Nickname:________________________ ❑ Male ❑ Female

School:______________________________ Grade:_______

Hobbies/Sports:___________________________________

Child's Home#: ( )_____________ SS#_______________

Child's Home Address:______________________________

____
City State Zip

2 Who Is Accompanying The Child Today?

Name:________________________ Relation:____________

Do you have legal custody of this child? ❑ Y ❑ N

Whom may we Thank for referring you? ________________

List brothers/sisters with age:_________________________

____

General Dentist:____________________________________

Last Exam Date:__________________Any cavities?______

Parent's Marital Status: ❑ Single ❑ Married
❑ Widowed ❑ Divorced ❑ Separated

3 Parent's Information

Mother ❑ Step Mother ❑ Guardian

Name:______________________ DOB:_________________

Cell #:( ) __________________

Wk#:( )___________________

Email:____

Employer:____

Title: ______________________

SS#:_____________________ DL#:___________________

Father ❑ Step Father ❑ Guardian

Name:______________________ DOB:_________________

Cell#:( ) ________________Wk#:( )__________________

Email:____

Employer:____

Title: ______________ Email: _____________________

SS#:_____________________ DL#:___________________

4 Person Responsible For Account

Name:______________________ Relation:_______________

Billing Address:_____________________________________

____
_ City State Zip

Email:____

Cell#: ( )________________ DL#:____________________

Employer:____

Wk#: ( )______________________

SS#:____

5 Primary Dental Insurance

Dental Coverage? ❑ Yes ❑ No Ortho? ❑Yes ❑ No

Insurance Co. Name:________________________________

Insurance Co. Address:______________________________

Insurance Co. Phone#: ( )___________________________

Group# (Plan, local, or Policy #):_____________________

Policy Owner's Name:________________________________

Relationship to Patient:______________________________

Policy Owner's DOB:_________________________________

Policy Owner's SS#:__________________________________

6 Does/did the Child Have Any of the Following?

Y N Clenching/Grinding Teeth
Y N Lip Sucking/Biting
Y N Mouth Breather
Y N Nail Biting
Y N Nursing Bottle Habits
Y N Speech Problems
Y N Thumb/Finger Sucking
Y N Tongue Thrust

Please Fill Out Page Two of This Form

7 WHAT WOULD YOU LIKE ORTHODONTICS TO ACCOMPLISH?

____

____

____

Has the child ever been evaluated or had orthodontic treatment before? Y N

Have there been any injuries to the face, mouth, teeth or chin? Y N

List any musical instruments played ____________________

Have adenoids or tonsils been removed? Y N

Has your child been informed of any missing or extra permanent teeth? Y N

Has the child even had any pain / tenderness in his / her jaw joint (TMJ/TMD)? Y N

Does the child brush his/her teeth daily? Y N

Floss his/her teeth daily? Y N

Child's Physician: ___________________________________

Phone#: ( )____

Date of Last Visit:____________________________________

Is child currently under the care of a physician? Y N

Has puberty begun? Y N

Has menstruation begun? (Girls) Y N

Please describe the child's current physical health:

❑ Good ❑ Fair ❑ Poor

Please list all drugs that the child is currently taking:

____

____

____

Please list all drugs/things that the child is allergic to:

____

8 HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS:

Y N Abnormal Bleeding
Y N Allergies to Any Drugs
Y N Allergic to Latex/Metals
Y N Allergic to Plastics
Y N Any Hospital Stays
Y N Any Operations
Y N Asthma
Y N Cancer
Y N Congenital Heart Defect
Y N Convulsions/Epilepsy
Y N Diabetes
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N HIV +/ AIDS
Y N Kidney/Liver Problems
Y N Rheumatic/Scarlet Fever
Y N Tuberculosis (TB)

9

I understand that the information that I have given is correct to the best of my knowledge, that is will be held in the strictest of confidence and 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.

____

Signature of parent or guardian Date

This office reserves the right to verify the credit status of potential patients and/or prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting agencies.

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Signature of parent or guardian Date

The Parent or Guardian who accompanies the child is responsible for payment at times of service unless prior arrangements have been made.
Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDA and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally retrieved the medical / dental information above with the parent / guardian & patient named herein.

Doctor's Comments Initials: ___________ Date: ____________

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