# Child Health History

KIM BATTERSON
ORTHODONTICS
For Children, Teens, & Adults

Today's Date: _____ Nickname:_____ ☐ Male ☐ Female

Child's Name: _____ Birthdate: _____ Age: _____

Child's Home Address_____

School: _____Grade: _____

Hobbies / Sports: _____

**Who is Accompanying Your Child Today?** Name: _____ Relation: _____

Do you have legal custody of this Child? _____ Who Referred You? _____

Other Family Members Seen by us:_____

General Dentist: _____ Last Visit: _____

Parents Marital Status _____ Whom may we thank for referring you to our practice? _____

**Mother's Information**

Name: _____ Birthdate: _____

Email Address: _____

Home Phone #: _____ Cell Phone #: _____ SS#: _____

Employer: _____ Work #: _____

**Father's Information**

Name: _____ Birthdate:_____

Email Address: _____

Home Phone #: _____ Cell Phone #: _____ SS#: _____

Employer: _____ Work #: _____

**Person Responsible for Account**

Name: _____ Relationship: _____

Billing Address _____ SS#: _____

Phone #: _____ Work #_____ Employer: _____

**Primary Insurance** Orthodontic Coverage? ☐ Yes ☐ No ***Please Provide Copy of Insurance Card***

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Co. Phone #:_____ Group #: _____ Policy Owner's SSN: _____

Policy Owner Name: _____ Relationship to Patient: _____

Policy Owner's Birthday: _____ Policy Owners Employer: _____

Employer's Address: _____

**Secondary Insurance** Orthodontic Coverage? ☐ Yes ☐ No ***Please Provide Copy of Insurance Card***

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Co. Phone #:_____ Group #: _____ Policy Owner's SSN: _____

Policy Owner Name: _____ Relationship to Patient: _____

Policy Owner's Birthday: _____ Policy Owners Employer: _____

Employer's Address: _____

What are the main concerns that you would like orthodontics to accomplish? _____

_____

Has your child ever been evaluated or had orthodontics treatment before? Yes No

Have there been any injuries to the face, mouth, teeth or chin? Yes No

List any musical instruments played: _____

Have adenoids and/or tonsils been removed? Yes No

Has your child been informed of any missing or extra permanent teeth? Yes No

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ / TMD) Yes No

Does your child brush his/her teeth daily? Yes No

Floss his/her teeth daily? Yes No

Child's Physician: _____

Date of Last Visit: _____

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

Has puberty begun? Yes No

Has menstruation begun? (Girls) Yes No

Has voice changed? (Boys) Yes No

Has grown facial hair? (Boys) Yes No

Please describe you child's current physical health

Good Fair Poor

Please list all medications that your child is currently taking:

_____

_____

Please list all medications/things that your child is allergic to:

_____

_____

**Is your child allergic to Latex, Metals/Nickel, and Plastics? Y N**

_____

**Has your child ever had any of the following medical problems?**

| | | | |
|---|---|---|---|
| Abnormal Bleeding | Y N | Handicaps/Disabilities | Y N |
| ADD / ADHD | Y N | Hearing Impairment | Y N |
| Any Hospital Stays | Y N | Heart Murmur | Y N |
| Any Operations | Y N | Hemophilia | Y N |
| Artificial Bones / Joints / Valves | Y N | Hepatitis | Y N |
| | | Bone Disorder/ Bone Loss | Y N |
| Arthritis | Y N | | |
| Asthma | Y N | HIV + / AIDS | Y N |
| Cancer | Y N | Kidney/Liver Problems | Y N |
| Congenital Heart Defect | Y N | Lupus | Y N |
| Seizures/Epilepsy | Y N | Rheumatic/ Scarlett Fever | Y N |
| Diabetes | Y N | Tuberculosis (TB) | Y N |

Does your child require premedication? Y N

Treated for emotional problems? Y N

Growth Problems? Y N

Hormone Problems? Y N

**Please discuss any medical problems that your child has had:**

_____

_____

_____

Has your child experience any of the following?

| | | | | | |
|---|---|---|---|---|---|
| Clenching / Grinding Teeth | Y | N | Snoring | Y | N |
| Lip Sucking / Biting | Y | N | Speech Problems/Therapy | Y | N |
| Mouth Breather | Y | N | Thumb/Finger Sucking | Y | N |
| Nail Biting | Y | N | Tongue Thrust | Y | N |
| Chews with Mouth Open | Y | N | Hard to Wake Child After Plenty of Sleep? | Y | N |
| Frequent Headaches | Y | N | | | |

# PRIVACY NOTICE

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.);
- To third party payors or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- To your family and close friends involved in your treatment; and/or,
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect;
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of **April 14, 2003**. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

**Neighbor or Relative not living with you.**

Name: _____

Phone: _____

Address: _____

_____

I, _____, have had full opportunity to read and consider the content of this consent form and your Notices Privacy Practices. I understand by signing this consent form, I am giving my consent to your use and disclosure of necessary protected health information to carry out treatment, payment activities, and health care options.

Signature:_____ Date:_____

If this consent is signed by personal representative on behalf of the patient, complete the following:

Patient or Legal Guardian: _____

Relationship to Patient: _____

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the diagnosis of any records of treatment or examination rendered, to my insurance company.

_____

Signature Date

**OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

**Doctor's Comments:** **Initials: _____ Date: _____**

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