Anderson Orthodontics

*Patient Registration and Health History - Child*

## 1 About You

Child's Name: _____

Prefers to be called: _____

Age: _____ □ Male □ Female

Birthdate: (mo/day/yr) ____/____/_____

Home Phone: _____

Other Phone: _____

Home Address: _____

_____

Parent/Guardian: _____

Other family members seen by us: _____

Does your child live with you? □ Yes □ No

## 2 Account Information

Name: _____

Relation: _____

□ Single □ Married □ Divorced □ Widowed

Birthdate:_____/_____/_____ SS #:_____

Occupation: _____

Employer: _____

Business Phone: _____

**SPOUSE**:

Name: _____

Birthdate:____/____/_____SS #: _____

Occupation: _____

Employer: _____

Business Phone: _____

Emergency Contact: _____

Relation: _____ Phone: _____

## 3 Dental Insurance

Policy Holder: _____ Relation: _____

Insurance Co: _____

Insurance Address: _____

Insurance Phone #: _____

Ins.ID #: _____

Group #: _____

Insured's Birthdate:____/____/_____

Insured's SS#: _____

Insured's Employer: _____

I hereby authorize payment of the dental benefits, otherwise payable to me, directly to Dr. Eric Anderson DMD. I understand I am responsible for any charges not covered by my insurance company.

_____

Subscriber signature Date

## 4 Privacy Consent

The information that I have given today is correct to the best of my knowledge. This information is used in our office as part of the treatment process. It can also be shared with providers outside the office under the following circumstances:

Information required for receiving dental benefits will be shared with the insurance company.

Information regarding treatment may be shared with the patient's dental provider. This information is limited to treatment and may include treatment summaries, photos and radiographs.

_____

Signature Date

## 5 Health History

| | Yes | No |
|---|---|---|
| Is the patient being treated by a physician at this time? | ❑ | ❑ |
| Has the patient ever been hospitalized? | ❑ | ❑ |
| Does your child have any allergies: _____ | ❑ | ❑ |
| Is your child taking any medications: _____ | ❑ | ❑ |
| Does your child suck his/her thumb, finger or pacifier? | ❑ | ❑ |
| Is your child adopted | ❑ | ❑ |

**Has the patient ever been diagnosed as having any of the following conditions?**

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Arthritis | ❑ | ❑ | Heart Disease | ❑ | ❑ |
| Asthma | ❑ | ❑ | Hepatitis | ❑ | ❑ |
| Bleeding Problems | ❑ | ❑ | HIV or AIDS | ❑ | ❑ |
| Cancer | ❑ | ❑ | Liver Disease | ❑ | ❑ |
| Cleft Lip/Palate | ❑ | ❑ | Vision/Hearing | ❑ | ❑ |
| Diabetes | ❑ | ❑ | Heart Issues | ❑ | ❑ |
| Epilepsy | ❑ | ❑ | Other _____ | | |

## 6 Dental History

Dentist_____ Date of Last Visit_____

How often do you brush per day: ❑ 1X ❑ 2X ❑ 3X ❑ 4+

Do you floss? ❑ Yes ❑ No

**Areas of Concern** (Circle all that apply):

| | | | |
|---|---|---|---|
| Crowding | Missing/Extra teeth | Cross-bite | Speech Problems |
| Spacing | Overbite | Late Eruption | Jaw Problems |

**History of the following** (Circle all that apply):

| | | | |
|---|---|---|---|
| Trauma to Teeth/Face | Mouth breathing | Snoring | Tongue Thrust |
| Grinding/Clenching | Headaches/Earaches | Previous orthodontic treatment | |

Family history of bite problems (Explain)

_____

Is there anything we should know about your child?

_____

_____

_____ _____ _____

Signature of parent/guardian Date Doctor Signature