PLEASE COMPLETE, PRINT AND BRING THIS FORM WITH YOU ON YOUR FIRST VISIT

Santa Monica Orthodontics
Love Your Smile!

CHILD HEALTH HISTORY FORM PAGE 1 of 4

Date: _____

Patient name: _____ Sex: ○ Male ○ Female
Last First Middle

Address: _____
Street City Zip

Nickname: _____ Birthdate: _____ Age: _____ Social Security #: _____

Sports/Hobbies: _____

Parent or Guardian name: _____

Whom may we thank for referring you to our office? _____

Where do you go to school/work? _____

# of Siblings: _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Marital Status: _____
Last First Middle

Residence: _____
Street City Zip

Mailing Address: _____
Street City Zip

How long at this address? _____ Home phone: _____ Work phone: _____

Cell/other phone: _____ E-mail address: _____

Previous Address (if less than 3 years): _____

_____

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: _____

Whom may we thank for referring you to our office? _____

ORTHODONTIC INSURANCE INFORMATION

Insured's Name: _____ Insured's Social Security #: _____

Insurance Company Name: _____ Group No.: _____ Subscriber ID: _____

Insurance Co. Address: _____ Phone No.: _____

Do you have dual coverage? ○ Yes ○ No If yes: _____

Insured's Name: _____ Insured's Social Security #: _____

Insurance Company Name: _____ Group No.: _____ Subscriber ID: _____

Insurance Co. Address: _____ Phone No.: _____

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CHILD HEALTH HISTORY FORM PAGE 2 of 4

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____

Complete address: _____
Street City Zip

Phone: _____

MEDICAL HISTORY

Physician: _____ Date of Last Visit: _____

Address: _____ Phone: _____

Please circle Yes or No

Yes No Are you in good health? If No, please explain: _____

Yes No Are you under the care of a Physician? If Yes, please explain: _____

Yes No Are you taking any medication? Birth control? If Yes, please list: _____

Yes No Are you allergic to any medication? If Yes, please list: _____

Yes No Are you allergic to Latex?

Yes No Do you have a history of a major illness? If Yes, please list: _____

Yes No Have you had any operations? If Yes, please list: _____

Yes No Have you ever been involved in a serious accident? If Yes, please explain: _____

Yes No Have you ever taken any weight-loss medications, i.e. PhenFen? If Yes, please list: _____

Yes No Do you have a cardiac pacemaker, artificial heart valve, heart murmur, or need to pre-medicate? If Yes, please explain: _____

Yes No Is there any family history of diabetes, heart murmur, or need to pre-medicate? If yes, please explain: _____

Yes No Have you ever smoked or chewed tobacco?

Yes No Have you seen a physician in the last 12 months? If yes, please explain: _____

Female Patients Only:

Yes No Are you pregnant? If Yes, how many months? _____

Yes No Have you started menstruating? If yes, when? _____

Circle any of the medical conditions below that you have had or currently have:

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver Problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hay Fever	Gastrointestinal Disorders	HIV / AIDS	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney Problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

_____

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CHILD HEALTH HISTORY FORM PAGE 3 of 4

DENTAL HISTORY

General Dentist: _____ Date of last visit: _____

What are your primary dental concerns? _____

Please circle Yes or No

- Yes No Are you presently in any dental pain?
- Yes No Have you ever experienced any unfavorable reaction to dentistry including anesthetic?
- Yes No Have you ever had injuries to your face, mouth, or teeth?
- Yes No Have your wisdom teeth been removed?
- Yes No Have you ever lost or chipped any teeth?
- Yes No Is any part of your mouth sensitive to temperature? Where? _____
- Yes No Is any part of your mouth sensitive to pressure? Where? _____
- Yes No Do your gums bleed when you brush?
- Yes No Do you have any type of thumb or tongue habit? _____
- Yes No Are you a mouth-breather?
- Yes No Have you ever seen an orthodontist? If yes, who and when? _____
  What is your attitude toward receiving orthodontic treatment? _____
  _____
- Yes No Would you object to wearing orthodontic appliances (braces) should they be indicated?
- Yes No Would you object to wearing orthodontic appliances (head gear) should they be indicated?
- Yes No Has anyone in your family received orthodontic treatment?
  How did they feel about the result? _____
- Yes No Do your teeth or jaws ever feel uncomfortable when you wake in the morning?
- Yes No Are you aware of your jaw clicking or popping?
- Yes No Are you aware of clenching your teeth during the day?
- Yes No Have you ever been told that you grind your teeth?
- Yes No Do you have “tension” headaches?
- Yes No Have you ever experienced chronic ringing in your ears?
- Yes No Does the patient need extra help with instructions?
- Yes No Is the patient sensitive or self-conscious about his/her teeth?
  Height of parents? Mom: _____ Dad: _____
- Yes No Are you aware that some appointments will be during school hours?

BENEFITS OF ORTHODONTICS

Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are intricate body parts and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime, and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history.

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CHILD HEALTH HISTORY FORM PAGE 4 of 4

In addition, I authorize Dr. Rehana Khan/Santa Monica Orthodontics to perform a complete orthodontic evaluation.

Parent's signature: _____ Date: _____

Medical History Update: Have there been any changes in your health since your last appointment? If Yes, please explain:_____

Are there any medical conditions that we have not discussed, which you feel we should be aware of? If Yes, please explain:_____

Parent's signature: _____ Date: _____

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

Parent signature: _____

Updates (date & initial): _____