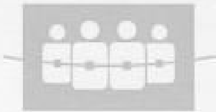

CROWDER
ORTHODONTICS

WELCOME!

CHILD HEALTH HISTORY

ABOUT YOUR CHILD

TODAY'S DATE: ____________________

Child's Name: ____________________ Preferred Name: ____________________
Birthday: ____________ Age: ________ Male Female
Home Address: ____________________ City: ____________ State: ______ Zip: ________
Home #: ____________________ School: ____________________ Grade: ________
Hobbies/sports/special interests: ____________________
How did you hear about our office? ____________________
Names and ages of other children: ____________________

PARENT

Mother's Name: ____________________
DOB: ____________________ SS#: ____________________
Home Address ____________________
Home #: ____________ Cell #: ____________ Work #: ____________
Email Address: ____________________
Employer: ____________________ Occupation: ____________________
Father's Name: ____________________
DOB: ____________________ SS#: ____________________
Home Address ____________________
Home #: ____________ Cell #: ____________ Work #: ____________
Email Address: ____________________
Employer: ____________________ Occupation: ____________________

RESPONSIBLE PARTY

Person Responsible for Account: ____________________
Billing Address: ____________________
Home #: ____________ Cell #: ____________ Work #: ____________
Relationship: ____________________ Employer: ____________________

INSURANCE INFORMATION

Primary Insurance: Dental Coverage? ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No Medical Coverage? ☐ Yes ☐ No
Insurance Co. Name: ____________ Phone #: ____________ Insured's Birthdate: ____________
Social Security #: ____________ Insurance Co. Address: ____________________
Insured's Name: ____________ Relationship: ____________ Group (Plan/Local/Policy) #: ____________
Insured's Employer: ____________ Employer's Address: ____________________

Secondary Insurance: Dental Coverage? ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No Medical Coverage? ☐ Yes ☐ No
Insurance Co. Name: ____________ Phone #: ____________ Insured's Birthdate: ____________
Social Security #: ____________ Insurance Co. Address: ____________________
Insured's Name: ____________ Relationship: ____________ Group (Plan/Local/Policy) #: ____________
Insured's Employer: ____________ Employer's Address: ____________________

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

DENTAL HISTORY

What are the main concerns that you would like orthodontics to address? ______________________

Have you ever been evaluated for orthodontic treatment? ☐ Yes ☐ No
By whom?______________________ When? ______________________

Injuries to face, mouth or teeth?______________________

Has your child experienced problems with past dental work? ☐ Yes ☐ No

Any missing/extra teeth? ______________________

Previous/Present Dentist:______________________ Date of last visit:______________________

Any difficulty with swallowing or chewing______________________

Does/did your child have any of the following habits?

☐ Lip Sucking/Biting ☐ Clenching/Grinding Teeth ☐ Tongue/Cheek Biting ☐ Mouth Breather

☐ Nail Biting ☐ Thumb/Finger Sucking ☐ Speech Problems ☐ Chewing on Objects

☐ Tongue Thrust

MEDICAL HISTORY

Is patient adopted?__________ at what Age?__________.

Child's Physician:______________________ Phone #:______________ Date of Last Visit:______________

Address: ______________________

Is your child currently under the care of a physician? ☐ Yes ☐ No Please Explain: ______________________

Describe your child's current physical health: ☐ Good ☐ Fair ☐ Poor Are immunizations current: ☐ Yes ☐ No

Please list all drugs that your child is currently taking: ______________________

Please list all drugs and/or things that cause your child allergic reactions:______________________

Adolescent females: Has menstruation begun? ☐ Yes ☐ No

Has your child experienced any of the following:

☐ ADD/ADHD ☐ Cancer ☐ Heart Problems/Murmur ☐ Rheumatic Fever

☐ Abnormal Bleeding ☐ Chicken Pox ☐ Hepatitis ☐ Seizures

☐ Allergies ☐ Cleft Lip/Palate ☐ High/Low Blood Pressure ☐ Tonsils/Adenoids removed

☐ Anemia ☐ Congenital Heart Defect ☐ (HIV+) Immune Def. ☐ Tuberculosis (TB)

☐ Asthma ☐ Emotional Problems ☐ Hospital Stay/Operations ☐ Other not listed

☐ Autism ☐ Diabetes ☐ Kidney/Liver Problems

☐ Blood Disorders ☐ Handicaps/Disabilities ☐ Latex Allergy

☐ Bone/Joint Problems ☐ Hearing Impairment ☐ Mononucleosis

Please discuss any serious medical problems your child has/had experienced:______________________

____

AUTHORIZATION

I affirm that the information I have given is correct to the best of my knowledge, and that 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 services that my child may need. I assign Dr. Crowder all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible and co-payment that my insurance does not cover. I understand that where appropriate, credit bureau reports may be obtained.

Signature:______________________ **Date:** ______________

CHARLES N. CROWDER, DMD MPH MS

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