Salem Smiles
ORTHODONTICS

Sarah C. Shoaf, DDS, MEd, MS, PC

CONFIDENTIAL MEDICAL/DENTAL HISTORY FORM - CHILD

PATIENT INFORMATION

Patient's name ____ Child's preferred name ____________________
First, Middle, Last

Patient's address ____
Street City State Zip

Home phone # ______________ Mom Cell phone # ______________ Dad cell phone # ________________ (Circle best #)

Parent Email address: ____________________________________ Child's DOB _____/______/______ Sex: M F

Who is filling in this form? Name: ____

Relationship________________________ Do you have legal custody? YES NO

Patient's General Dentist _______________________________ How did you hear about our office? ________________

Have we treated a member of your family? YES NO If YES, Name ____

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

RESPONSIBLE PARTY INFORMATION

Responsible Party 1 ____________________________________ Relationship to Patient ____________________________________

Home address ____ Home Phone # ________________________

Responsible Party 2 ____________________________________ Relationship to Patient ____________________________________

Home address ____ Home Phone # ________________________

DENTAL HISTORY - now or in the past has your child had (please circle):

Yes No Any teeth removed for any rea son?
Yes No Supernumerary (extra) or congenitally missing teeth?
Yes No Chipped or otherwise injured primary (baby) or permanent teeth?
Yes No Teeth sensitive to hot or cold, teeth throb or ache?
Yes No Jaw fractures, cysts or mouth infections?
Yes No "Dead teeth" or root canals treated?
Yes No Periodontal problems, bleeding gums?
Yes No Thumb, finger or sucking habit? Until what age? _______
Yes No History of speech problems?
Yes No Ever had a prior orthodontic examination or treatment?
Date of past treatment____________________________________

Yes No Snoring, sleep apnea? PSG test date ______________
Yes No Tooth grinding, jaw clenching, clicking or locking?
Yes No Pain in jaw?
Yes No Difficulty chewing or jaw opening?
Yes No Aware of loose, broken or missing fillings?
Yes No Any teeth irritating cheek, lip, tongue or palate?
Yes No Frequent canker sores or cold sores?
Yes No Any wisdom tooth problems?
Yes No Wisdom teeth removed? Date _______________
Yes No Is your child sensitive or self-conscious about his/her teeth?
Yes No Presently wearing retainer/mouth guard?

Other concerns about your child's teeth not listed? ____

MEDICAL HISTORY - now or in the past has your child had (please circle):

Yes No Birth defects or hereditary problems?
Yes No Rheumatoid or arthritic conditions?
Yes No Kidney problems?
Yes No Cancer, tumor, radiation treatment or chemotherapy?
Yes No Problems of the immune system? AIDS or HIV positive?
Yes No Fainting spells, seizures, epilepsy, or neurological problems?
Yes No Vision, hearing problems other than corrective lenses?
Yes No Excessive bleeding or bleeding disorder?
Yes No Cardiovascular problems such as chest pain, heart attacks, stroke, inborn heart defects, heart murmurs, angina?
Yes No Does your child chew or smoke tobacco?

Yes No Bone fractures, any major accidents?
Yes No Endocrine or thyroid problems?
Yes No Diabetes?
Yes No Stomach ulcer, GERD, or frequent heartburn?
Yes No Hepatitis, jaundice or liver problems?
Yes No Mental health disturbance or behavioral problems?
Yes No History of eating disorder (anorexia, bulimia)?
Yes No High or low blood pressure?
Yes No Hayfever, asthma, sinus trouble?
Yes No Tonsil or adenoid conditions?
Yes No Girls – are you pregnant?

List allergies to all medications, latex, or metals ______________________________

List all medications, herbal supplements, vitamins, or over the counter medications presently taken: ______________________________

____

Dates and reasons for any hospitalizations: ______________________________

Are there any other medical conditions that we should be aware of? ______________________________

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will inform this practice at my next visit. Furthermore, I consent to an orthodontic examination and treatment of my child.

Signed: ______________________________ Date signed ______________
(Parent/Guardian)

Signed: ______________________________ Date signed ______________
(Dental staff member receiving form)

FINANCIAL AGREEMENT

--- We accept assignment of MOST insurance plans. Your insurance is a contract between you, your employer, and the insurance company; our relationship is with you, NOT the insurance company.
--- ALL charges incurred are charged directly to YOU and you are personally responsible for payment. Deductibles and co-payments are due at the time of treatment. We estimate your co-payments according to your policy. WE DO NOT in any way guarantee that your insurance will pay this amount.
--- If the insurance company doesn't pay within a reasonable amount of time, it is required that you pay the balance due.
--- Your insurance card must be presented at every visit. If there is no insurance card then payment (cash, or credit card) is expected at the time of service.
--- I hereby authorize payment directly to Sarah C. Shoaf, DDS, MEd, MS, PC/Salem Smiles the insurance benefits otherwise payable to me, and authorize release of any information required to process insurance claims for my child.
--- If your account is more than 2 months past due your account will be turned over to Interstate Credit Collections.

______________________ ______________________ ____________
Parent/Guardian Signature Parent/Guardian Social Security Number Date

PARENT/INSURANCE INFORMATION

Self Father Stepfather Mother Stepmother Guardian (circle one)

Name ______________________ SS# ______________________ DOB ____________

Address (if different from patient) ______________________________

Home Phone ______________ Cell Phone ______________ Work Phone ______________

Employer ______________________________

List Insurance Coverage

Insurance Company ______________________ Phone Number ______________________

Claims Address ______________________________

Group # ______________________ Policy/ID # ______________________

Updated Health History/ Personal Information:	Date: ________ Initials: ______	Date: ________ Initials: ______	Date: ________ Initials: ______	Date: ________ Initials: ______	Date: ________ Initials: ______	Date: ________ Initials: ______