HILLSBORO ORTHODONTICS

the art of a beautiful smile

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Registration and Health History (for Minors)

ABOUT YOUR CHILD

Patient's Name: ______________________ Nickname: ______________

Age: ________ Sex: ________ Birthday: ______________ School: ______________________ Grade: ______

Home address: ____
STREET CITY STATE ZIP

Cell phone: ______________________ Email: ______________________

Whom may we thank for referring you to this office? ______________________

Names of other family members treated by our office: ______________________

Parent or guardian's name: ______________________ Work phone: ______________

RESPONSIBLE PARTY

Name: ____
LAST FIRST MIDDLE

Residence (if different from child): ____
STREET CITY STATE ZIP

Years at this address ______________ Home phone: ______________ Work phone: ______________

Previous address (if less than three years): ____
STREET CITY STATE ZIP

Soc. Sec. # ______________ Birthdate: ______________ Relationship to patient: ______________

Employer: ______________________ Occupation: ______________________ # Years ________

Spouse's name: ____
LAST FIRST MIDDLE

Soc. Sec. # ______________ Birthdate: ______________ Relationship to patient: ______________

Employer: ______________________ Occupation: ______________________ # Years ________

DENTAL INSURANCE

Insured's name: ______________________ Insured's Soc., Sec. #: ______________

Primary Insurance Co: ______________________ Group #: ______________ Local #: ______________

Insurance Co address: ____
STREET CITY STATE ZIP

Do you have dual coverage? ☐ Yes ☐ No

If yes: Insured's name: ______________________ Insured's Soc. Sec. #: ______________

Secondary Insurance Co: ______________________ Group #: ______________ Local #: ______________

Insurance Co address: ____

GENERAL INFORMATION

Names and ages of other children in family: ______________________

Leisure time activities (hobbies) that the patient enjoys: ______________________

Has any member of the family had orthdontic treatment? ☐ Yes ☐ No If so, who? ______________

I authorize Hillsboro Orthodontics to furnish information necessary for processing of all charges by my insurance and assign Hillsboro Orthodontics all monies paid by my insurance toward the services performed.

Signature: ______________________________ Date: ______________________

(please complete other side)

DENTAL HISTORY

Date of child's last dental check-up (if known): ______________________

Name and address of your dentist: ______________________

Does your child still suck their thumb, finger, or lip (habit)? ☐ Yes ☐ No

Have there been any injuries to the face, mouth, or teeth? ☐ Yes ☐ No When? ____________

Does the patient have any speech problems? ☐ Yes ☐ No

Is your child a mouth breather? ☐ Yes ☐ No ☐ While asleep ☐ During the day

Have you been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Has another orthodontist been previously consulted? ☐ Yes ☐ No Whom? ____________

Have you previously undergone any orthodontic treatment? ☐ Yes ☐ No By Whom? ____________

Please give your reasons for having an orthodontic consultation: ______________________

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MEDICAL HISTORY

Date of child's last physical exam (if known): ______________________

Name and address of your child's pediatrician: ______________________

Do you have or have you had any of the following? (please indicate with a check mark)

☐ Any heart problems	☐ Allergies to anesthetics	☐ Hepatitis	☐ Sinus Problems
☐ High blood pressure	☐ Allergies to medicines/drugs	☐ Herpes	☐ Stroke
☐ Low blood pressure	☐ Allergies to __________	☐ Malignancies	☐ Typhoid fever
☐ Circulatory problems	☐ Nervous problems	☐ Measles	☐ Tonsillitis
☐ Radiation treatments	☐ Anemia	☐ Mumps	☐ Tuberculosis
☐ Excessive bleeding	☐ Arthritis	☐ Psychiatric care	☐ Ulcer
☐ AIDS/HIV positive	☐ Asthma	☐ Rheumatic fever	☐ Venereal disease
☐ Chronic headaches	☐ Diabetes	☐ Scarlet fever	
☐ Other			

Please indicate any medication(s) that your child is presently taking: ______________________

____

Is your child allergic to any medications? ☐ Yes ☐ No List: ______________________

____

Does your child smoke or chew tobacco? ☐ Yes ☐ No

Has your child ever been hospitalized? ☐ Yes ☐ No Why/date: ______________________

Has your child ever been seriously ill? ☐ Yes ☐ No Explain: ______________________

Has your child ever had a blood transfusion? ☐ Yes ☐ No

Has your child been tested for AIDS? ☐ Yes ☐ No

Is your child now under medical doctor care? ☐ Yes ☐ No Condition: ______________________

Doctor: ______________________

Has your child ever taken cortisone, steroids, or similar drugs? ☐ Yes ☐ No When? ____________

Has your child ever bled excessively from minor cuts, previous surgery, or following a tooth extraction? ☐ Yes ☐ No

Female patient: Has patient started her monthly period ☐ Yes ☐ No When: ____________

Has patient had any other signs of pubertal development (i.e. axillary hair, etc.)? ☐ Yes ☐ No

Male patient: Has patient had any signs of pubertal development (i.e. axillary hair, etc.)? ☐ Yes ☐ No

Has patient's voice changed? ☐ Yes ☐ No Has patient started to shave? ☐ Yes ☐ No

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment: ______________________

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