

HILLSBORO HILLSBORO ORTHODONTICS

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SPECIALIST IN ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS

Registration and Health History (for Minors)

ABOUT YOUR CHILD

Patient's Name: _____ Nickname: _____
Age: _____ Sex: _____ Birthday: _____ School: _____ Grade: _____
Home address: _____
STREET CITY STATE ZIP
Hm. 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 orthodontic 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: _____

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)

- | | | | |
|-----------------------------------------------|-------------------------------------------------------|-------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Any heart problems | <input type="checkbox"/> Allergies to anesthetics | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Allergies to medicines/drugs | <input type="checkbox"/> Herpes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Allergies to _____ | <input type="checkbox"/> Malignancies | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Nervous problems | <input type="checkbox"/> Measles | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Radiation treatments | <input type="checkbox"/> Anemia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> AIDS/HIV positive | <input type="checkbox"/> Asthma | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chronic headaches | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Scarlet fever | |
| <input type="checkbox"/> 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: _____