

CHILD REGISTRATION AND HEALTH HISTORY FORM



Patient's name _____ Social Security# _____

Nickname _____ Age _____ Sex _____ Birthdate _____

Address _____ City/Zip _____ Years at above address _____

Father's name _____ Occupation _____

Employer _____ Years with employer _____ Business phone _____

Mother's name _____ Occupation _____

Employer _____ Years with employer _____ Business phone _____

Home phone _____ Cell phone _____ (Mother Father)

Whenever possible, we try to give a courtesy (confirmation) call before your appointments. Which number would you like us to use? Preferred email contact _____ (Mother Father)

Parent's marital status: Single Married Widowed Separated Divorced

Person financially responsible for this account _____

If there is orthodontic insurance, insured's Social Security number _____ Date of birth _____

Whom do we contact in case of an emergency? (Other than parent?)

Name _____ Telephone _____

Father's/Mother's address if different from patient _____

Brother's/Sister's names and birthdates _____

Has anyone in the family had orthodontic care? (who?) _____

Is the patient adopted? _____ If "Yes", does the patient know? _____

Patient's physician _____ Telephone _____

Patient's dentist _____ Date of last dental cleaning _____

What are the patient's hobbies and sports? _____

Patient's school _____ Grade _____ Musical instruments played _____

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

Do you have any friends or relatives who come to our office? _____

Who noticed the orthodontic problem? Patient Parent Dentist Other _____

Describe the orthodontic concern in your own words. _____

What concerns you most about the thought of orthodontic treatment?

- | | | | |
|--------------------------|------------|----------------------|---------------------|
| Appearance in appliances | Discomfort | Quality of treatment | Low down payment |
| Cost | Results | Latest technology | Low monthly payment |
| Length of treatment | Comfort | Clear technology | |

I understand that appropriate credit bureau reports may be obtained.

Medical inquiries do not affect your credit score.

Signature (Patient's signature, if minor) _____ Date _____

Patient's name _____ Height _____ Weight _____

AN EXPLANATION

It is our desire to offer the finest treatment for you and/or your child. In order to plan the best treatment, it is important that we understand the medical/dental background of our patients. While some of the questions may seem personal, the answers may be very important to our planned orthodontic treatment. Thank you for your cooperation.

- Is the patient under the care of a physician? (who and why?) yes no
- Does the patient have a health problem now? (what?) yes no
- Is the patient presently taking any medications? (what?) yes no
- Are antibiotics necessary for dental procedures? (what?) yes no
- Does patient have learning disabilities or needs extra help with instructions? yes no
- Does the patient have any allergies? (what?) yes no
- Have the tonsils and/or adenoids been removed? (what and when?) yes no
- Is there a history of ear infection, sore throats, or frequent colds? (which and how frequent?) yes no
- Has the patient been hospitalized in the past three years? (diagnosed condition?) yes no
- Does the patient have any mental or physical disability? (what) yes no
- Is there a history of injury to face, head, or teeth? (what and when?) yes no
- Does the patient have problems or pain in the jaw joint? (TMJ?) yes no
- Teeth grinding, jaw clenching, or any clicking, locking in jaw? yes no
- Does the patient have bleeding gums, gum problems, or history of periodontal (gum) treatment? yes no
- Is there a history of mouth breathing/snoring or difficulty breathing? (reasons?) yes no
- Is there a history of finger or thumb sucking? (until what age?) yes no

What are the chief concerns you have related to the position of your child's teeth or bite:

Aesthetic	Cleaning	Comfort	Ability to chew	Stability	Other: _____		
Does the patient chew or smoke tobacco?	yes	no	Any history of a substance abuse problem?	yes	no		
Girls only: Started her monthly period? (when?)	yes	no	Is the patient pregnant?	yes	no		
Boys: Has his voice changed? (when?)	yes	no					

Has the patient ever had any of the following:

AIDS or HIV Positive	yes	no	Cytomegalovirus	yes	no	Measles/Mumps	yes	no
Allergies (latex, metal, etc.)	yes	no	Diabetes	yes	no	Mononucleosis/Polio	yes	no
Anemia	yes	no	Epilepsy/Seizures	yes	no	Organ Transplant	yes	no
Arthritis/Rheumatoid Condition	yes	no	Heart Murmur	yes	no	Osteoporosis	yes	no
Asthma	yes	no	Cardiovascular/Heart Trouble	yes	no	Psychiatric Treatment	yes	no
Bleeding Disorder	yes	no	Hepatitis	yes	no	Shortness of Breath	yes	no
Cancer Treatment	yes	no	Herpes (any type)	yes	no	Sinus Trouble	yes	no
Canker Sores	yes	no	High or Low Blood Pressure	yes	no	Stroke	yes	no
Chicken Pox	yes	no	Endocrine/Thyroid Problems	yes	no	Swelling of Ankles	yes	no
Chronic Cough	yes	no	Jaundice/Liver Problems	yes	no	Tuberculosis	yes	no
Congenital Heart Lesion	yes	no	Kidney Problems	yes	no	Venereal Disease	yes	no

I hereby certify that I have read and understand the above questions and that the information provided is accurate to the best of my knowledge. I will not hold Dr. Gen or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes to this history later, I will inform this practice. I also consent to the making of diagnostic records, including x-rays before, during, and following orthodontic treatment.

Parent's signature _____ Doctor's signature _____ Date _____

PEDIATRIC SLEEP QUESTIONNAIRE

Patients under 18 years of age



Last Name _____ First Name _____ Age _____ Date _____

Please answer on behalf of your child for the past month. If you don't know, please circle "?"

WHILE SLEEPING, DOES YOUR CHILD:

- Snore more than half the time? Yes No ?
- Always snore? Yes No ?
- Snore loudly? Yes No ?
- Have trouble breathing, or struggle to breathe? Yes No ?
- Have "heavy" or loud breathing? Yes No ?
- Have you ever seen your child stop breathing during the night? Yes No ?
- Have restless or agitated sleep? Grinding teeth? Yes No ?
- Have abnormal head posture (hyper-extension, etc.) Yes No ?

DOES YOUR CHILD:

- Tend to breathe through the mouth during the day? Yes No ?
- Have a dry mouth or waking up in the morning? Yes No ?
- Occasionally wet the bed? Yes No ?
- Wake up feeling unrefreshed in the morning? Yes No ?
- Have a problem with sleepiness during the day? Yes No ?
- Has a teacher commented that your child appears sleepy during the day? Yes No ?
- Is it hard to wake your child up in the morning? Yes No ?
- Does your child wake up with headaches in the morning? Yes No ?
- Did your child stop growing at a normal rate at any time since birth? Yes No ?
- Is your child overweight? Yes No ?
- Frequently sick, has a history of sore throat, ear infections, sinus infections or allergies? Yes No ?
- Has habits such as pacifier/ thumb sucking/ lip biting/ other? Yes No ?

MY CHILD OFTEN:

- Does not seem to listen when spoken to directly Yes No ?
- Has difficulty organizing tasks and activities Yes No ?
- Is easily distracted by extraneous stimuli Yes No ?
- Fidgets with hands or feet or squirms in seat Yes No ?
- Is "on the go" or often acts as if "driven by a motor" Yes No ?
- Interrupts or intrudes on others (e.g. butts into conversations or games) Yes No ?