

Anthony T. Young, D.D.S., M.S. - Orthodontist

CHILD REGISTRATION AND HEALTH HISTORY

Name _____ Birthdate _____ Nickname _____

Home Address _____ City _____ Zip _____ Home Phone _____

Grade _____ School _____ Town _____

Child's Favorite: Person _____ Hobby _____ Sport _____ Fictional character _____

Brother's & Sister's Names & Ages: Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____ Name _____ Age _____

Mother's Name _____ Birthdate _____ Social Security # _____ / _____ / _____

Occupation _____ Employed by _____

Mother's Business Address _____ Business Phone _____

[Mother's Home Address if Different] _____

Father's Name _____ Birthdate _____ Social Security # _____ / _____ / _____

Occupation _____ Employed by _____

Father's Business Address _____ Business Phone _____

[Father's Home Address if Different] _____

Parent Marital Status (Circle one) Married Divorced Separated Unmarried Widowed

Name of Legal Guardian if Other than Parent _____

Physician's Name _____ Address _____ Phone _____

Dentist's Name _____ Address _____ Phone _____

Whom May I Thank for Referring You Here: _____

Their City, Address, &/or Phone # if known: _____

This Consultation Was Prompted by (Circle all that apply): patient mother father dentist sibling spouse friend

Please Check Your Child's Expected Interest Level Very Interested and Wants Treatment...
 Disinterested and May be Unwilling, But Agrees to Participate in Treatment...
 Not Willing and Cooperation not Likely.

Please note the following financial information:

- Custom monthly payment schedules are arranged so all fees are paid in full before appliances are removed.
- You will receive a financial agreement to sign for my professional services.
- No statements are sent - coupon books are available.
- Your initial consultation and panoramic x-ray are complimentary.

PRIMARY INSURANCE CARRIER _____ YOUR INSURANCE ID NUMBER _____

ADDRESS _____ PHONE _____

SECONDARY INSURANCE CARRIER _____ YOUR INSURANCE ID NUMBER _____

ADDRESS _____ PHONE _____

DENTAL HISTORY

Approximate date of last dental checkup _____

Approximate date of last dental treatment _____

For what procedure? _____

Has your child had toothbrushing instructions? Yes No
...flossing instructions? Yes No

How often does your child:
brush? Daily Weekly Rarely Never
floss? Daily Weekly Rarely Never

Has your child had professional fluoride treatments? Yes No
Have your child's teeth been "sealed" by a dentist? Yes No

IF No PERTAINS TO THE FOLLOWING, CHECK No,
IF YOU CHECK Yes PLEASE STATE REASON(S) WHY:

Oral habits, i.e., thumb sucking, nail biting, mouth breathing, nursing habits, chewing (i.e., pencils or ice), pacifier, etc.? Yes No

Which ones? _____

Unusual feelings toward dentistry? Yes No

Any unhappy dental experiences? Yes No

Injuries to the mouth or teeth? Yes No

Trauma to head and/or neck? Yes No

Car/sports accidents? Yes No

Unusual speech habits? Yes No

ANY OF THE FOLLOWING CONDITIONS PRESENT?

Extensive dental restorations? Yes No

Jaw joint problems? Yes No

Bruxing (tooth grinding)? Yes No

Tooth sensitivity? Yes No

Gum problems? Yes No

Mom have braces? Yes No

Dad have braces? Yes No

Dad's height _____ ft _____ in

Mom's height _____ ft _____ in

MEDICAL HISTORY

Approximate date of child's last physical exam: _____

Was your child found to be healthy? Yes No

If not please briefly explain: _____

Is your child under the care of a physician now? Yes No

For what? _____

Is your child on medication now? Yes No

If yes, what medication? _____

Has your child ever been hospitalized? Yes No

Why? _____

Has your child ever had surgery? Yes No

Why? _____

Will cooperation be a problem? Yes No

Why? _____

Does your child have good coordination? Yes No

Are there significant emotional problems? Yes No

If so, how are they being addressed? _____

PLEASE PLACE A MARK BEFORE EACH CONDITION YOUR CHILD HAS A HISTORY OF OR BEEN EXPOSED TO:

- | | |
|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Bladder disorders |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Bone disorders |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Cerebral palsy |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Frequent sore throats | <input type="checkbox"/> Hearing disorder |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Head or facial injuries |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> HIV Exposure | <input type="checkbox"/> Hormone problems |
| <input type="checkbox"/> Kidney disorders | <input type="checkbox"/> Learning disability |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Mouth breather while sleeping |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Psychology disorders |
| <input type="checkbox"/> Respiratory disorders | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Skin disorders | <input type="checkbox"/> Snore loudly |
| <input type="checkbox"/> Speech disorders | <input type="checkbox"/> Thyroid disorders |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> Virus-type colds frequently | |

Is there anything not covered above that is important that I should know about for your child's health and well being? Yes No

This Information Given By: _____

Relation to Child: _____

Date: _____ Updated: _____

Signature of Parent/guardian