Child **New Patient Questionnaire and Health History**: Hiller Orthodontics

Patient's name: ____ Today's date: ____/____/______

Birth date: ____ /____ /______ Age: _______ School: ______________________________________

Child's Home Address: ____

Primary phone number of parent/guardian: (______) ________-___________ Home Cell Work

Mother's Name: _________________________________ SSN: _____-____-_____ DOB: ___/___/____

Father's Name: _________________________________ SSN:_____-____-_____ DOB:___/___/____
Child resides with_______________________________
Name and ages of siblings? ____
Who may we thank for referring you to Dr. Hiller? ____

Responsible Party's information:

Name: ____ DOB: _____/_____/_____
Address:____
City:____ Zip code: ________________
Employer's name: ____

E-mail address: ______________________________________ **SSN**: _______-_______-________

Phone numbers: (Home): _______________(Cell): _________________ (Work): ________________

Do you have Dental/Orthodontic Insurance for your Child? ___ Yes ___ No

Name of Insurance carrier: ____
Insurance carrier's phone #: (_____) ______-________________
Policy Holder's Name: ____ SSN: _____-____-______
Policy Holder's Date of Birth: ____ /____ /_____
Subscriber ID #: ____________________________ Group#: ________________________________
Policy Holder's Employer: ____

Child's **General Dentist**: ____________________________________ Last visit: _________________
Child's **Physician**: ____ Last visit: _________________

Is the child currently under treatment by a Physician? ___ Yes ___ No

If Yes, Explain:____

____

List all medications child is currently taking:
____

____

Has the child ever had any of these following medical conditions? (circle if yes)

HIV/AIDS, Artificial bones/joints/valves, Congenital heart defect, frequent headaches, Heart murmur, Heart attack,

Hepatitis A or B, High Blood Pressure, Bleeding disorders, Mitral Valve Prolapse, Convulsions, Diabetes, Asthma,

Radiation Therapy, Anxiety Disorder, ADHD/ADD, Depression, Anxiety, Anorexia/Bulemia, facial or dental trauma/injury

Please list any serious medical conditions that the child has now or has had in the past:

____

____

Is the child allergic to any of the following? (circle if yes)

Aspirin, Codeine, Penicillin, Erythromycin, Tetracycline, Latex, Metals, Dental anesthetics, Nickel, plastics

List any other allergies: ____

Boys: Has puberty started? ___Yes ___ No
Girls: Has menstruation started? ___ Yes ___ No

Has your child experienced any of the following: (circle if yes)

Clenching/grinding teeth, lip biting/sucking, mouth breathing, nail biting, speech problems, finger/thumb sucking,

tongue thrust, popping/clicking jaw joints, jaw muscle pain, not able to chew, not able to open mouth wide

What are the main concerns about your child's teeth you would like orthodontic treatment to correct or improve?

____

Does the child require antibiotics before dental treatment?	YES	NO
Has the child ever experienced an injury to their teeth, mouth, or chin?	YES	NO
Have the tonsils and/or adenoids been removed?	YES	NO
Currently, do any of the child's teeth hurt, throb, or ache?	YES	NO
Currently, are any of the child's teeth sensitive to cold or hot?	YES	NO
Does the child brush their teeth every day?	YES	NO

List any musical instruments played: ____

List any sports played: ____

I understand that the information that I have given today is correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my child's medical /dental status. I authorize Dr. Hiller and his staff to perform any necessary dental/orthodontic services that my child may need.

___ ***Yes,*** *I agree with the above statement*

Signature of Parent/Guardian:___________________________________ Date: ________________

Reviewed by:____ Date: ________________

Doctor's Comments: