

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: