Conlon & Thompson Orthodontics, Ltd.

DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

SPECIALISTS IN ORTHODONTICS FOR CHILDREN & ADULTS

Members American Association of Orthodontists

815.344.2840 Fax 815.344.2859

HEALTH HISTORY (For Minors)

ABOUT YOUR CHILD

Patient's Name: _____ I prefer to be called: _____
LAST FIRST MIDDLE

Age: ____ Sex: _____ School: _____ Grade: _____ Birthdate: _____

Home Address: _____
STREET CITY STATE ZIP

Home Phone: _____ Mom Cell Phone: _____

Dad Cell Phone: _____

Email: _____

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

Did your dentist recommend an orthodontic evaluation? Yes / No

Names of other family members treated by our office: _____

CUSTODIAL PARENT / GUARDIAN

Name: _____
LAST FIRST MIDDLE

☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single

Residence, if different from child: _____
STREET CITY STATE ZIP

Home Phone: _____ Work Phone: _____

Soc. Sec. #: _____ Birthdate: _____ Relationship to Patient: _____

Employer: _____ Occupation: _____ # Years: _____

Employer Address _____ Work Phone: _____

Spouse's Name _____ Relationship to Patient: _____
LAST FIRST MIDDLE

Employer: _____ Occupation: _____ # Years: _____

Employer Address _____ Work Phone: _____

Soc. Sec. #: _____ Birthdate: _____

DENTAL INSURANCE

Primary Insured's Name: _____ ID #: _____ DOB: _____

Primary Insur. Co.: _____ Group #: _____

Insurance Co. Address: _____ Phone No. _____

Secondary Insured's Name: _____ ID #: _____ DOB: _____

Secondary Insur. Co.: _____ Group #: _____

Insurance Co. Address: _____ Phone No. _____

Your signature below authorizes assignment of insurance benefits

Signature _____ Date _____

(please complete other side)

DENTAL HISTORY

Date of last dental check-up: _____

Name and address of your child's 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 awake? ☐Yes ☐No

While asleep? ☐Yes ☐No

Has another orthodontist been consulted previously? ☐Yes ☐No

Please give your reasons for having an orthodontic consultation _____

_____

PATIENT MEDICAL HISTORY

Date of last physical exam: _____

Name and address of your pediatrician/physician: _____

Do you have or have you had any of the following. Please indicate with a check mark (✓).

☐ Any heart problems
☐ High blood pressure
☐ Low blood pressure
☐ Circulatory problems
☐ Nervous problems
☐ Radiation treatments
☐ Excessive bleeding
☐ AIDS/HIV positive
☐ Other _____
☐ ADD/ADHD

☐ Allergies to anesthetics
☐ Allergies to medicines/drugs _____
☐ Allergies to latex
☐ Allergies to nickel/metals
☐ Allergies to_____
☐ Arthritis
☐ Asthma

☐ Anemia
☐ Diabetes
☐ Hepatitis
☐ Herpes
☐ Cancer_____
☐ Measles
☐ Mumps
☐ Psychiatric care

☐ Rheumatic Fever
☐ Scarlet Fever
☐ Sinus Problems
☐ Stroke
☐ Thyroid
☐ Tonsilitis
☐ Tuberculosis
☐ Ulcer
☐ Venereal Disease
☐ Chronic headaches

Is the patient required to Pre-Medicate prior to dental visits? _____

Please indicate any medication(s) that your child is presently taking _____

_____

Is the patient presently taking or has ever taken any cancer medications? ☐Yes ☐No

If yes, please list drugs and dates: _____

_____

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your child's dental treatment.

_____

GENERAL INFORMATION

Names and birthdates of other children in family _____

_____

Sports you participate in: _____

Leisure time activities (hobbies) that the patient enjoys: _____

_____

Parent's Signature: **X** _____ Date: _____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.