Child History Form

Date

A B C

Aesthetic Orthodontics for Adults and Children

Patient Information

Patient's Last Name | First Name | Middle Initial | Birth Date

Address | City | State | Zip

Home Phone | Alternate Phone *(Cell/Work)* | Social Security Number

Parent's/Guardian's Name | Whom May We Thank for Referring You to Our Office?

Confidential Responsible Party Information

Responsible Party's Last Name | First Name | Middle Initial | Birth Date

Residence Address | City | State | Zip | Years at Address

Mailing Address | City | State | Zip

Home Phone | Cell Phone | Work Phone | Email

Previous Address *(If at Current Address for Less Than Three(3) years)* | City | State | Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Social Security Number | Relationship to Patient | Marital Status

Employer | Occupation | Years at Employer

Spouse's Last Name | First Name | Middle Initial | Birth Date

Social Security Number | Relationship to Patient | Daytime Phone Number

Employer | Occupation | Years at Employer

Dental Insurance Information

Policy Holder's Name | Social Security Number | Employer

Insurance Company Name | Phone Number | Group Number | Union/Local Number

Insurance Company Address | City | State | Zip

Do You Have Dual Coverage? ☐ Yes ☐ No

Policy Holder's Name | Social Security Number | Employer

Insurance Company Name | Phone Number | Group Number | Union/Local Number

Insurance Company Address | City | State | Zip

Emergency

Last Name *(Nearest Relative NOT Currently Living with You)* | First Name | Relationship to Patient

Address | City | State | Zip | Daytime Phone Number

weberorthodontics
210 West Willow • Wheaton, Illinois 60187-5239
Tel: 630.665.5552 Fax: 630.665.0701 www.weberortho.com

Thank You for Completing Both Sides of This History Form

Child History Form

Dental Information

What is the Primary Reason for Your Visit?

Do You Wish to Discuss Anything with Dr. Weber in Private? ☐ Yes ☐ No

Have You Been Evaluated for or Had Previous Orthodontic Treatment? ☐ Yes ☐ No

If Yes, By Whom

Date of Last Orthodontist Visit

Family Dentist Name

Phone

Date of Last Dental Visit

Family Physician Name

Phone

Date of Last Physician Visit

Medical and Dental History

Medical History Information

Please Check "Yes" or "No" if Patient has or had the Following Ailments.

Joint Swelling	☐ Yes ☐ No	Anemia	☐ Yes ☐ No
Bone Disorders	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No
Heart Trouble	☐ Yes ☐ No	Prolonged Bleeding	☐ Yes ☐ No
Mitral Valve Prolapse	☐ Yes ☐ No	Faintness/Dizziness	☐ Yes ☐ No
Thyroid Problems	☐ Yes ☐ No	Tonsils Removed	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Adenoids Removed	☐ Yes ☐ No
Psychological Problems	☐ Yes ☐ No	Sore Throats	☐ Yes ☐ No
Brain Injury	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Kidney or Liver Involvement	☐ Yes ☐ No	Earaches	☐ Yes ☐ No
Joint Prosthesis	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No

On Items Checked "Yes", Please Provide Us with a More Detailed Description

Dental History Information

Please Check "Yes" or "No" if Patient has or had the Following Oral Issues.

Any Injuries to Face, Mouth or Teeth?	☐ No	☐ Face	☐ Mouth	☐ Teeth
Thumb, Finger or Lip Sucking?	☐ No	☐ Thumb	☐ Finger	☐ Lip
Any Missing Permanent Teeth?	☐ No	☐ Yes		
Any Extra Permanent Teeth?	☐ No	☐ Yes		
Any Teeth Removed by Extractions?	☐ No	☐ Yes		
Difficulty in Swallowing or Chewing?	☐ No	☐ Yes		
Pain or Clicking on Opening/Closing Mouth?	☐ No	☐ Yes		
Difficulty in Opening/Closing the Mouth?	☐ No	☐ Yes		
Does Patient Visit the Dentist Regularly?	☐ No	☐ Yes		

What Would You Like to Have Orthodontic Treatment Accomplish?

Additional Information

Any Additional Serious Illnesses Not Shown Above?

All Known Allergies

Drugs or Medications Currently Being Taken

Is Patient Currently Under a Physician's Care? ☐ Yes ☐ No

If Yes, Please Describe Reason for Care

Siblings

Siblings Name — Age

Siblings Name — Age

Siblings Name — Age

Siblings Name — Age

Declaration

Name *(Please Print)*

Signature

Date Completed

I hereby certify that the information I have given is correct to the best of my knowledge and that it is my responsibility to inform this office of any changes. I, the above signed, do hereby relinquish any and all rights to photographs, portraits, transparencies, negatives, prints, Polaroids or other photographic reproduction captures with still, motion picture, video, digital or other cameras for use by Weber Orthodontics. I understand that where appropriate, credit bureau reports maybe obtained. *We are sorry that we cannot accept divorce decrees as assignments of responsibility for a child's orthodontic bills. The parent accompanying the child should pay for the services and seek any reimbursement from the other parent.*

Office Only

Doctor Signature *(Reviewer of Health History)* — Date of Interview/Review — Comments

T.C. Signature *(Reviewer of Health History)* — Date of Review — Comments

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