

## Child (18-years-old) Intake and Medical History Form

Please answer completely and to the best of your knowledge. This information is protected under HIPAA regulations.

Patient full name: \_\_\_\_\_ Preferred name: \_\_\_\_\_

Gender: \_\_\_\_\_ Birthday: \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_

Ethnic heritage: \_\_\_\_\_ Hobbies/interests: \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_

School name: \_\_\_\_\_

Responsible party: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address (if different): \_\_\_\_\_

Cell: \_\_\_\_\_ Alt. phone: \_\_\_\_\_ Email: \_\_\_\_\_

Other contact information: \_\_\_\_\_

Preferred method of non-emergency contact (please check):    Email    Text    Cell    Other: \_\_\_\_\_

Occupation and employer: \_\_\_\_\_

Legal guardian(s) of patient (if different): \_\_\_\_\_

Patient living with (please check):    Mother    Father    Grandparents    Other: \_\_\_\_\_

Dental insurance company: \_\_\_\_\_ Group number: \_\_\_\_\_

Insured name: \_\_\_\_\_ Policy number: \_\_\_\_\_

Group name and group contact phone number: \_\_\_\_\_

Emergency contact (non-guardian/responsible party): \_\_\_\_\_

Cell: \_\_\_\_\_ Alt. phone: \_\_\_\_\_ Email: \_\_\_\_\_

General dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last dental exam: \_\_\_\_\_ History of cavities, extractions or toothache:    Y or N

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

List medical conditions: \_\_\_\_\_

List medications: \_\_\_\_\_

Emergency medical visits in the last three years: \_\_\_\_\_

List surgeries: \_\_\_\_\_

List allergies (medicine, foods, metals, general): \_\_\_\_\_

Any additional past relevant medical conditions: \_\_\_\_\_

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Main orthodontic concern: \_\_\_\_\_

Have you had a previous orthodontic consultation? Y or N With whom? \_\_\_\_\_

Did you have a panoramic radiograph (x-ray) taken recently (last 6 months)? Y or N or I don't know

How did you hear about our office? \_\_\_\_\_

Has anyone in the family had orthodontic treatment? Who? \_\_\_\_\_

Any history of the following (Y or N):

Thumb or finger sucking after five-years-old: Y or N Pacifier use after five-years-old: Y or N

Pain or discomfort in jaws or joint: Y or N Dental anxiety: Y or N

Self-consciousness about teeth: Y or N Snoring: Y or N

Poor breathing through nose: Y or N Speech therapy: Y or N

Excessive sleepiness or tiredness: Y or N Cheek or nail biting: Y or N

Tongue thrust: Y or N Depression, anxiety or bipolar: Y or N

Anorexia or bulimia: Y or N Tobacco or marijuana use: Y or N

Additional dental, medical or social issues that have not been address and should be identified: Y or N

Describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I have completed this form to the best of my knowledge and not withheld any dental or medical history. Should there be a change or development in the dental or medical history I will make Dr. Schofield aware as soon as possible.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_