ARIZONA ORTHODONTICS EXCLUSIVELY, PC

Howard L. Henry DDS MSc

www.arizonaorthodonticsexclusively.com
Orthodontics for children and adults

CHILD HEALTH HISTORY FORM

Welcome! Our specialty is creating smiles, and to do this we treat people, not just teeth! We are about your total health and appreciate your time in this health history.

DATE:

Child's Name		PATIEN'	T INFORMA	TION				
Name Child prefers to be called	Child's Name	TITIET			's DOB / /	Age		
Name Child results and sure an		First	Middle			Weight		
Child's Home Address								
Child's Shome Name Parent F-Mail Address (used for appointment reminders/x-ray & photo viewing, kept confidential): Sports/Hobbies Names and Ages of Other Family Members Names of Other Family Members Treated in this Office Who may we thank for referring you to our Office? Who is accompanying this child today? Your Name (Natural Parent? Pes DNO) (Child Adopted Pes DNO) (Foster Parent? Pes DNO) (Other- Specify Relationship PARENT'S INFORMATION Mother's Marital Status Married Divorced Widow Single Remarried Divorced Work Ph. Employer Father's Marital Status Married Divorced Widow Single Remarried Divorced Wid	Child's Home Address		City		State	Zip		
Child's School Name Grade Parent E-Mail Address (used for appointment reminders/x-ray & photo viewing, kept confidential): Sports/Hobbies Musical Instrument Played Names and Ages of Other Family Members Names of Other Family Members Treated in this Office? Who may we thank for referring you to our Office? Who is accompanying this child today? Your Name Your relationship to Child (Natural Parent? O'Yes O'No) (Child Adopted O'Yes O'No) (Foster Parent? O'Yes O'No) (Other- Specify Relationship PARENT'S INFORMATION Mother's Marital Status Married Divorced Widow Single Remarried Mother Stepmother Officer Address City State Zip Home Ph. Work Ph. Employer Father's Marital Status Married Officer Midow Single Remarried Mother Officer Married Mother Officer Married Mother Officer Officer Mother Officer Mother Officer Offic	Child's Home Phone #							
Sports/Hobbies	Child's School Name		Gra	de				
Sports/Hobbies	Parent E-Mail Address (used for	appointment reminders/x-ray &	photo viewing, ke	ept confidenti	al):			
Name Address City State Zip Work Ph. Employer Work Ph. Evening Phone # INSURANCE INFORMATION Primary Insurance Information Relationship to Patient Insurance Phone # Work Ph. State Zip Name of Dental Plan Work Ph. Employer Work Ph	Sports/Hobbies	TF	Mus	sical Instrume	ent Played			
Name Address City State Zip Work Ph. Employer Work Ph. Evening Phone # INSURANCE INFORMATION Primary Insurance Information Relationship to Patient Insurance Phone # Work Ph. State Zip Name of Dental Plan Work Ph. Employer Work Ph	Names and Ages of Other Famil	v Members						
Who may we thank for referring you to our Office? Who is accompanying this child today? Your Name Your relationship to Child	Names of Other Family Member	rs Treated in this Office						
Who is accompanying this child today? Your relationship to Child			ffice?					
Mother's Marital Status	Who is accom	nanving this child today?						
Mother's Marital Status	Your Name	panying and came today.	Your relationship	to Child				
Mother's Marital Status	(Natural Parent? ¬Yes ¬No.) (C	hild Adopted □Yes □ No) (Foster	Parent? ¬Yes ¬N	o) (Other- Sp	ecify Relationship			
Mother's Marital Status	(·) (· · · · · · · · · · · · · · · · ·				
Mother's Marital Status								
Mother		PARENT	'S INFORMA	TION				
Name Address City State Zip Home Ph	Mother's Marital Status	□ Married □ Divorced	□ Widow	□ Single	□ Remarried			
Home Ph.	\Box Mother \Box Stepmother	□ Guardian						
Home Ph.	Name	Address		City	State	Zip		
Father's Marital Status Married Divorced Widow Single Remarried Father Stepfather Guardian Address City State Zip Work Ph. Employer	Home Ph .	Work Ph.		Employ	er			
Father	Father's Marital Status	☐ Married ☐ Divorced	□ Widow	□ Single	□ Remarried			
Name Address City State Zip Work Ph. Employer PERSON(S) RESPONSIBLE FOR THIS ACCOUNT Name Address City State Zip SS # Daytime Phone # Evening Phone # Name Address City State Zip SS # Daytime Phone # Evening Phone # INSURANCE INFORMATION Primary Insurance Information Insured's Name Insured's DOB Insured SS # Employer's Name Employer's Phone # Employer's Address City State Zip Insurance Company City State Zip Insurance Phone # Name of Dental Plan (We will need a copy of your "Dental Plan Insurance Card") Secondary Insurance Information Insured's Name Employer's Phone # Employer's Name Employer's Phone # Employer's Name Insurance Information Insured's DOB Insured SS # Employer's Name Employer's Phone # Employer's Name State Zip Insurance Phone # Name of Dental Plan				Č				
Person(s) responsible for this account				City	State	Zip		
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Relationship to Patient Insured SS #	SS #	Daytime Phone #_			_Evening Phone #			
Insured's Name		INSURAN	CE INFORM.	ATION				
Insured's Name	Primary Insurance Informatio	n	Relationship to	Patient				
Employer's Name	Insured's Name					#		
Employer's Address City State Zip Insurance Company City State Zip Insurance Phone # Name of Dental Plan (We will need a copy of your "Dental Plan Insurance Card") Secondary Insurance Information Insured's Name Insured's DOB Insured SS # Employer's Name Employer's Phone # Employer's Address City State Zip Insurance Company City State Zip Insurance Phone # Name of Dental Plan								
Insurance Company City State Zip Insurance Phone # Name of Dental Plan (We will need a copy of your "Dental Plan Insurance Card") Secondary Insurance Information Insured's Name Insured's DOB Insured SS # Employer's Name Employer's Phone # Employer's Address City State Zip Insurance Company City State Zip Insurance Phone # Name of Dental Plan	Employer's Address					Zip_		
Insurance Phone # Name of Dental Plan			City —		State	Zip		
City State Zip			Name of Dental	l Plan		1		
Secondary Insurance Information Relationship to Patient Insured's Name Insured's DOB Insured SS # Employer's Name Employer's Phone # Employer's Address City State Zip Insurance Company City State Zip Insurance Phone # Name of Dental Plan	· · · · · · · · · · · · · · · · · · ·	(We will need a copy of	vour "Dental Pla	n Insurance	Card")			
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Insurance Phone # Name of Dental Plan	Insurance Company		City		State	7in		
	Insurance Phone #		Name of Dantal	l Plan	State	Zip		
	monance i none #				Card") (Continu	red on Opposite Side		

Rev	iewed	l with 1	patient by					Date	e			
						MEDICAL						
Phy	sician					City	Date of	f Last	Visit			
		's Add	Iress			City		S	state Zip	Phon	e #	
			es or No (If Yes,)	please fil	l in th	e details)						
Yes		No	Are you taking			.9						
Yes	1	No	Are you allergion	e to any n	nedica	tion?						
Yes	1	No	Are you present	tly under	care c	of a physician? Yes N	o Do yo	ou hav	e a history of major i	llness?		
Yes	1	No	Have you ever l	had any n	najor (operation? Yes No E	ver beer	hospi	italized?			
Yes	1	No	Have you ever l	been invo	lved i	n a serious accident?						
Yes	1	No	Have you had y	our tonsi	ls or a	denoids removed?						
Yes	1	No	Have you ever l	had any o	f the f	denoids removed? following: Asthma	A	llergie	s Hayfever	Throat	Infecti	ons
	I	f so, w	hat are you allerg	gic to?								
Plea	ise cir	rcle th	e appropriate an	swer for	the n	nedical conditions bel	low:					
Yes	No	Abno	rmal Bleeding	Yes	No	Endocrine Problems	Yes		Liver Disease	Yes	No	Tuberculosis
Yes	No	Aneı		Yes		Epilepsy	Yes	No	Lung/Respiratory	Yes		AIDS
Yes	No	Arth		Yes		Glaucoma			Disease	Yes		HIV +
Yes	No		d Disorders	Yes		Heart Murmur	Yes		Nervous Disorders	Yes		Contact Lens
Yes	No		e or Joint Disorders	Yes		Heart Problems	Yes		Prelanged Pleading	Yes		Other
Yes	No		cer/Tumor	Yes Yes	No	Hepatitis-Type Herpes	Yes Yes		Prolonged Bleeding Rheumatic Fever		ma, na ty? Ye	ve you reached s No
Yes	No	Diab		Yes		High Blood Pressure	Yes		Rheumatic Heart		-	ou started
Yes	No		iness/Fainting	Yes		Hyperactive			Thyroid Disease			n? Yes No
Yes	No		tional Problems	Yes		Kidney Involvement	Yes	No	Sinusitis	Boys, has your		
						•					Ye	
_												
						DENTAL	HIST	ORY	7			
Den	tist								Date of Last Visit_			
		Addre	SS			_City			State Zip	Pho:	ne#_	
Who	at con	cerns	you most about y	our teeth	?							
Doe	s the	patien	t want the teeth s	traighten	ed? _							
			ef Concern?									
						lowing questions, and			eeded:			
Yes		No	Have there ever	been any	/ injur	ies to the face, mouth	or teeth'	'				
Yes		No	Have you ever l	been info	rmed	of missing, extra or ch	ipped te	eth?_				
Yes		No				sed teeth?						
Yes		No	Is any part of yo	our mouth	ı sens	itive to temperature or	pressure	e?				
Yes		No				brush your teeth?						
Yes		No				b or tongue habit?						
Yes	1	No	Have you ever l	had any s	peech	therapy? If yes, how the: nose mo	long? _					
	_		Do you breathe	mostly th	irough	n the: nose mo	uth	bo	th uncertain _			
Yes		No	Do you have Th	MJ?		9						
Yes		No	Are you aware	oi any joi	nt noi	se?						
Yes		No	100 you have an	iv iaciai n	ain!							
Yes		No	Do you have an	y pain or	soren	ess around your face, comfortable when you	neck or l	back?				
Yes		No	Are your teeth of	or jaws ev	er un	comfortable when you	awaken	in the	e morning?			
Yes		No	Are you aware	of jaw cli	cking	or popping?						
Yes		No	Are you aware	ot clench	ing yo	or popping?	y?					
Yes		No	Have you ever	been told	tnat y	ou grind your teeth? _						
Yes		No	Do you have "to	ension" h	eadac	hes?						
Yes		No	Do you have "f	reauent''	heada	ches?						
Yes		No	Have you ever	experienc	ed ch	ronic ringing in your e	ars?					
Yes		No	Have you or an	yone in y	our fa	mily had orthodontics'	?					
Yes		No	Does the patien	t resembl	e Mot	her and/or Father?						
Yes	1	No	Does anyone in	the famil	y hav	e similar dental condit	ion?					
						DENETITE OF	NDTHA	$\mathbf{M} \mathbf{M}$	TH 10			

Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime, and there can be some movement of the teeth, and some change after treatment. I hereby state that I have read and understand the above paragraph, and that I have truthfully to the best of my ability answered all the above questions.

Aesthetics, Health and Function

Orthodontics is a service that provides an improvement in the appearance of the teeth, and in the general function of the teeth, and in general dental health.

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