WELCOME TO Bright Star Orthodontics

Child's Health History

Today's Date___ /___/____

Patient's Name:______________________________

Patient's Birthday___/___/____ Age____ M F

Mom Cell # (_____)_________________________

Mom Email:______________________________

Dad Cell # (_____)_________________________

Dad Email: ______________________________

Address:

____

City___________________State______Zip_____

Who is accompanying the patient today?

Name:___________________________________

Relation:_________________________________

Do you have legal custody of the patient? Y N

Referred by:______________________________

General Dentist:___________________________

Last visit date:____/____/_____

Do you have any Brothers or sisters? Y N

Who is responsible for the account?

Name:____________________ DOB____/____/____

Address:(if different)

____

City___________________State______Zip________

SS#:______-_____-______

Employer:_______________________________________

Occupation:_____________________________________

Dental Insurance

Insurance Co. Name: _________________________

Insurance Address:___________________________

City______________________State_____Zip______

Insurance Phone:(_____)______________________

Insurance ID #: ____________________________

Group #: __________________________________

Name:____________________ DOB____/____/____

Address:(if different)

____

City___________________State______Zip________

SS#:______-_____-______

Employer:_______________________________________

Occupation:_____________________________________

Dental Insurance

Insurance Co. Name: _________________________

Insurance Address:___________________________

City______________________State_____Zip______

Insurance Phone:(_____)______________________

Insurance ID #: ____________________________

Group #: __________________________________

Authorization

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If Bright Star Orthodontics PA accepts the insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions. Whether manual or electronic.

Signature of Parent or Guardian_________________________________Date_________

Dental & Medical History

What are the main concerns that you would like orthodontics to accomplish?

____

Has your child ever been evaluated or had orthodontic treatment before? Y N
Have there been any injuries to the face, mouth or chin? Y N
Does the child require antibiotics before dental treatment? Y N
Have adenoids or tonsils been removed? Y N
Does your child have any missing or extra permanent teeth? Y N
Has the child ever had any pain/ tenderness in his/her jaw joint (TMJ/TMD) Y N
Does the child brush his/her teeth daily? Y N
Floss his/her teeth daily? Y N

Is the child under the care of a physician? Y N
If YES, list physicians name and phone #

Name:_________________Phone #: (_____)__________

Date of Last Visit: ____/____/______

Has puberty begun? Y N
Has menstruation begun? Y N

Please describe the child's current physical health:

Good [ ] Fair [ ] Poor [ ]

Please list all drugs that the child is currently taking:

____

____

Allergies:

Latex	Y	N
Metals/Nickle	Y	N
Plastic	Y	N

Has your child experienced the following medical problems?

Abnormal Bleeding	Y	N	Hearing Impairment	Y	N
ADD/ADHD	Y	N	Heart Murmur	Y	N
AIDS/ HIV+	Y	N	Hemophilia	Y	N
Any Hospital Stays/Operations	Y	N	Hepatitis	Y	N
Artificial Bones/Joints/Valves	Y	N	Kidney Problems	Y	N
Asthma	Y	N	Liver Problems	Y	N
Cancer	Y	N	Mitral Valve Prolapse	Y	N
Congenital Heart defect	Y	N	Prosthetics	Y	N
Convulsions	Y	N	Pneumatic Fever	Y	N
Diabetes	Y	N	Scarlet Fever	Y	N
Epilepsy	Y	N	Sickle Cell Disease/Traits	Y	N
Handicaps/ Disabilities	Y	N	Tuberculosis (TB)	Y	N

Are the child's immunizations current? Y N

Anything you would like to discuss with the Doctor in private? Y N

Please discuss any serious medical problems the child has had:

____

Does/did the child have any of the following habits?

Nursing Bottle Habits	Y	N	Used pacifier at age 3	Y	N
Clenching/ Grinding Teeth	Y	N	Speech Problems	Y	N
Lip Sucking/ Biting	Y	N	Thumb/ Finger Sucking	Y	N
Mouth Breather	Y	N	Tongue Thrust	Y	N
Nail Biting	Y	N			

List any musical instruments played:

____

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

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental/ orthodontic services my child may need.

____
Signature of Parent or Guardian Date

OFFICE USE ONLY---OFFICE USE ONLY---OFFICE USE ONLY

I have verbally reviewed the medical/ dental information above with the parent/ guardian & patient named herein.

____
Signature of Dentist Date

Medical History Update

Has there been any change in your child's health status since their last visit? Y N

If Yes, please explain.______________________________

____

____
Parent/ Guardian Signature Date

____
Dentist Signature Date