CHILD HEALTH QUESTIONAIRE

(Confidential information necessary for your child's files and their health)

Today's Date_____

Patient's Name (first)_____(last)_____ **Birthdate**_____ **Age**____ **Gender** M / F
Address _____**City**_____**Postal Code**_____
School: _____

Dentist _____**Family Doctor**_____
Siblings' Names and Ages _____ _____

Mother's Name (first) (last) **Home #** _____
Cell#_____ **Would you like to receive appointment reminders by text? Y or N**
E-Mail_____ **Occupation:**_____
Address _____ City_____ Postal Code_____
(if different from Patient)

Father's Name (first) (last) **Home#**
Cell#_____ **Would you like to receive appointment reminders by text? Y or N**
E-Mail_____ **Occupation**:_____
Address _____ City _____ Postal Code_____
(if different from Patient)

Please check box

1. Is your child in good health?_____YES ☐ NO ☐

2. Has your child reached puberty?_____YES ☐ NO ☐
   Girls: menstruation started?_____YES ☐ NO ☐
   Boys: voice changed?_____YES ☐ NO ☐

3. Have you noticed a rapid rate of growth in the past year?_____YES ☐ NO ☐
   Height _____

4. Is your child adopted?(hereditary characteristics) _____YES ☐ NO ☐

5. How would you describe your child's temperament? _____

6. Has your child previously been or is currently under the care of a health care professional for any kind of specific condition or syndrome? If yes, please explain_____YES ☐ NO ☐

7. Has your child ever been hospitalized or had a serious illness or accident?_____YES ☐ NO ☐
   If Yes, explain:_____
8. Please list any medications your child is currently taking._____

   _____

9. Please list any illness that your child has had or currently has that required medical attention
   Has had:_____
   _____
   Currently has:_____
   _____

10. Please check any of these medications your child may have taken in the past year:

☐Penicillin ☐Blood thinners ☐Digitalis ☐Other_____
☐Cortisone ☐Tranquilizers ☐Thyroid
☐Nitroglycerin ☐Dilantin ☐Aspirin _____

11. Please check any of these items that your child has had a bad reaction to:

☐ Local Anesthetics ☐Codeine ☐Insulin ☐Barbituates
☐ Ibuprofen Penicillin ☐Aspirin ☐Iodine Other_____

12. Does your child suffer frequent colds?_____YES ☐ NO ☐

13. Does your child have difficulty breathing through the nose?_____YES ☐ NO ☐

14. Has your child had abnormal bleeding associated with previous extractions, surgery or trauma?_____YES ☐ NO ☐

15. Has your child (at any age) had an injury to their head, neck, face, teeth or chin? (Stitches, concussions, whiplash) YES ☐ NO ☐
If Yes, please explain:_____

16. Is there any other information we should know about your child's health or previous dental treatment? YES ☐ NO ☐
If Yes, please explain:_____

17. Does your child have a metal or latex sensitivity or allergy?_____YES ☐ NO ☐

18. Has your child had a recent exposure to any communicable infectious diseases? (measles, chicken pox or Tuberculosis) YES ☐ NO ☐

19. In the last 24 hours has your child had a new cough, shortness of breath, fever, chills, diarrhea or other flu-like symptoms?_____ YES ☐ NO ☐

What is the main reason for seeking orthodontic care for your child? _____

PARENTAL CONSENT FOR A MINOR

I AUTHORIZE ALL NECESSARY DENTAL RECORDS AND EXAMINATIONS TO BE RENDERED FOR _____.
(Patient's Name)

Date: _____ **Signature:** _____ **Relationship:** _____

By signing above, you are also consenting to receive email correspondence from Authentic Orthodontics (this includes, but is not limited to; payment receipts, appointment reminders, and occasional patient contests) If you prefer not to receive emails from Authentic Orthodontics, please let us know.

INSURANCE INFORMATION

(Parent/Step Parent or Legal Guardian)

	Insurance Plan # 1	**Insurance Plan # 2 (if applicable)**
Plan Member Name :	_____	(2) _____
Plan member DOB :	_____	_____
Relationship to Patient :	_____	_____
Insurance Company	_____	_____
Group/Policy #	_____	_____
I.D./Certificate #	_____	_____

Name of the person who is financially responsible for the account :_____
Relationship to the patient:_____

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