FAMILY ORTHODONTIC CARE, P.C.

JENNIFER J. LOWNEY, D.M.D.
SUSAN J. DAVIS, D.M.D., M.S.
www.familyorthodonticcare.com

100 Sherman Street
Norwich, Connecticut 06360
(860) 886-1466

79 Norwich Avenue
Colchester, Connecticut 06415
(860) 537-1918

Child Health & History Form
(PLEASE PRINT & BRING WITH YOU TO APPOINTMENT)

Date ___/___/___

Patient's Last Name _____ First _____ MI _____

DOB ___/___/___ Age _____ Sex ____

Whom may we thank for referring you to our office _____

In Case We Cannot Reach You-Person to contact _____Phone _____

Name & Address of Family Dentist _____

Name & Address of Family Physician _____

Patient Current Weight _____ Patient Current Height _____

Current Medications _____

Has patient ever been hospitalized? Yes / No (if yes, reason)_____

Does patient have allergies to medications/materials (in particular Latex or Nickel)? Yes/ No

(If Yes, Explain)_____

Does patient have a condition requiring antibiotic prophylaxis before dental procedures? Yes / No

(If Yes, Explain)_____

Has the patient reached puberty? Yes / No Girl--Has she started menstruation? Yes / No
Boy- Has his voice changed? Yes / No

Name and Age of other children in the family_____

Hobbies, Sports & Musical Instruments_____

Are you aware that some orthodontic visits will be during school hours? Yes / No

Patient's School_____

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For the following questions circle yes, no or don't know/understand (dk/u). This information is for office use only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Yes	No	dk/u	Does patient follow directions?
Yes	No	dk/u	Does patient brush his/her teeth conscientiously?
Yes	No	dk/u	Does patient have learning disabilities or need extra help with instructions?
Yes	No	dk/u	Is patient sensitive or self-conscious?

Continue On Next Page

Patient Name_____

Medical History

Yes	No	dk/u	Birth defects or hereditary problems?
Yes	No	dk/u	Bone fractures or major accidents?
Yes	No	dk/u	Rheumatoid or arthritic conditions?
Yes	No	dk/u	Endocrine or thyroid problem?
Yes	No	dk/u	Kidney problems?
Yes	No	dk/u	Diabetes?
Yes	No	dk/u	Cancer or been treated for a tumor?
Yes	No	dk/u	Stomach ulcer or hyperacidity?
Yes	No	dk/u	Polio, mono, tuberculosis, pneumonia?
Yes	No	dk/u	Problems with immune system?
Yes	No	dk/u	AIDS or HIV positive?
Yes	No	dk/u	Hepatitis, jaundice, or liver problem?
Yes	No	dk/u	Fainting spells, seizures, epilepsy, or neurological problems?
Yes	No	dk/u	Mental Health or behavioral problems?
Yes	No	dk/u	Vision, hearing, tasting, or speech difficulties?
Yes	No	dk/u	Cardiovascular problems, rheumatic heart disease, heart murmur?
Yes	No	dk/u	Does patient currently or ever had a substance abuse problem?
Yes	No	dk/u	Other physical problem or symptom?_____
Yes	No	dk/u	Being treated by another health care professional? For_____
			Date of last physical exam _____

Dental History

Yes	No	dk/u	Started teeth very early or late?
Yes	No	dk/u	Primary (baby) teeth removed that were not loose?
Yes	No	dk/u	Permanent or "extra" teeth removed?
Yes	No	dk/u	Supernumerary (extra) or congenitally missing teeth?
Yes	No	dk/u	Chipped or otherwise injured permanent teeth?
Yes	No	dk/u	Teeth sensitive to hot or cold; teeth throb or ache?
Yes	No	dk/u	Jaw fractures, cysts or mouth infections?
Yes	No	dk/u	"Dead teeth" or root canal treatment?
Yes	No	dk/u	Bleeding gums, bad taste, mouth odor?
Yes	No	dk/u	Periodontal "Gum problems"?
Yes	No	dk/u	Food impaction between teeth?
Yes	No	dk/u	"Gum boils", frequent canker sores, cold sores?
Yes	No	dk/u	Is child taking any forms of fluoride?
Yes	No	dk/u	Thumb finger sucking habit? Until_____
Yes	No	dk/u	Abnormal-swallowing habit (tongue thrusting)?
Yes	No	dk/u	History of speech problem?
Yes	No	dk/u	Mouth breathing habit, snoring, difficulty in breathing?
Yes	No	dk/u	Tooth grinding, jaw clenching, clicking, locking?
Yes	No	dk/u	Any pain in jaws or ringing in ears?
Yes	No	dk/u	Any pain or soreness in muscles of the face, or around the ears?
Yes	No	dk/u	Difficulty in chewing or jaw opening?
Yes	No	dk/u	Aware of loose, broken or missing restorations (fillings)?
Yes	No	dk/u	Any teeth irritating cheek, lip, tongue, palate?
Yes	No	dk/u	Concerned about spaced, crooked, protruding teeth?
Yes	No	dk/u	Aware or concerned about under or over developed jaw?
Yes	No	dk/u	Any relative with similar tooth or jaw relationships?
Yes	No	dk/u	Any "wisdom tooth" problems?
Yes	No	dk/u	Has patient ever had a prior orthodontic examination or treatment?

Date of last dental visit _____ Any radiographs taken?_____

What would your child like to gain by orthodontic treatment?

☐	Eliminate dental crowding	☐	Move teeth so that bridges or implants can be made
☐	Treat overbite	☐	Easier cleaning teeth
☐	Treat underbite	☐	A nice smile
☐	Correct my profile	☐	_____ Other

I have answered these questions truthfully, and to the best of my knowledge. If there are any changes in my child's health/history information I will inform this practice.

Signature of Parent/Guardian_____ Date _____

Doctor Signature _____ Date_____

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CHILD REGISTRATION FORM
(PLEASE PRINT & BRING WITH YOU TO APPOINTMENT)

Date___/___/___

Patient Name-Last_____ First _____MI_____

Nickname_____ Email _____ DOB ___/___/___ Age _____ Sex _____

Street Address_____ City_____ ST_____ Zip_____

Home Tel_____ Cell_____ Emergency Contact_____ Phone _____

Mother's Name _____ DOB ___/___/___ S.S.#_____

Address *(if different than patient)* _____

Home Tel _____ Bus.Tel_____ Cell_____ Email_____

Employer _____ Can we call you at work? Yes / No

Employer Address_____

Father's Name_____ DOB ___/___/___ S.S.#_____

Address *(if different than patient)* _____

Home Tel_____ Bus.Tel_____ Cell _____ Email_____

Employer _____ Can we call you at work? Yes / No

Employer Address _____

INSURANCE

PRIMARY INSURANCE

Name of Insurance Company_____Orthodontic Max:$_____

Insurance Address _____

Subscriber's Name_____ DOB ___/___/___ Relationship to Patient _____

S.S.#_____ ID#_____ GROUP#_____

Employer Name & Address:_____

SECONDARY INSURANCE

Name of Insurance Company_____Orthodontic Max:$_____

Insurance Address _____

Subscriber's Name_____ DOB ___/___/___ Relationship to Patient _____

S.S.#_____ ID#_____ GROUP#_____

Employer Name & Address:_____

AUTHORIZATIONS

NOTIFICATION: I understand that a "soft" credit check may be obtained in order to offer flexible payment options to our patients. Creditors will not see this on your credit report.

I authorize Family Orthodontic Care, PC to release my protected health information to my dental benefit plan needed to carry out payment activities in connection with dental services rendered. I also agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan.

X_____
Patient/Guardian Signature Date

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Family Orthodontic Care, P.C.

X_____
Subscriber Signature Date

Family Orthodontic Care may call my business phone to reach me during the day to discuss treatment, scheduling, or account issues regarding myself / my child.

X_____
Patient/Guardian Signature Date

Family Orthodontic Care may discuss treatment, scheduling, or account issues regarding myself / my child with the following:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

X_____
Patient/Guardian Signature Date

ACKNOWLEDGEMENT

I understand that I may obtain and inspect a copy of Family Orthodontic Care's **Notice of Privacy Practices**, and will be given the opportunity to ask any questions I may have regarding this Notice.

Patient Name:_____ Parent/Guardian Name _____
(Please Print) If under 18 (Please Print)

Patient Signature:_____ Date _____
(Parent/Guardian if under 18)

Relationship to Patient_____